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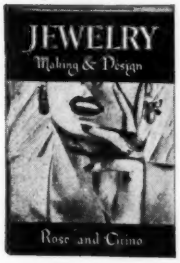

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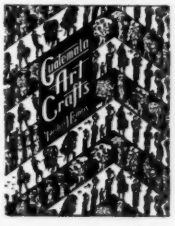

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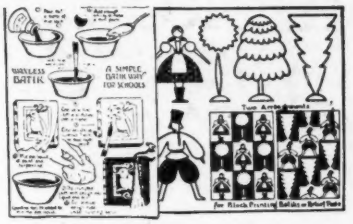

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The AMERICAN JOURNAL *of* OCCUPATIONAL THERAPY

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Occupational Therapy, A Psychiatric Treament

By ALFRED P. SOLOMON, M.D.
30 N. Michigan Avenue, Chicago, Ill.

The development and the recognition of occupational therapy as a psychiatric treatment curiously enough has been impeded by the very impetus that led to its birth. The humanitarian movement in which it had its roots and which took the psychotic out of dungeons and chains and put him into the fresh air with recreational and occupational diversions stimulated the use of occupational therapy for purposes of recreation and diversion. In fulfilling these functions, however, its development as a formal psychiatric treatment has remained sterile.

Records of recommendations for the use of what was to be called occupational therapy for the purpose of diversion, or keeping one's time pleasantly occupied, are to be found in the earliest writings on psychiatry. Dr. Peter Bassoe[1] in the last article of his career states that, "not Pinel, but physicians in Valencia in 1409, were the first to remove chains and institute moral treatment. Free exercises, games, occupational entertainment, diet, and hygiene were used." In the same article he quotes Ullersperger as stating that, "in early Egypt there existed a Saturn temple devoted to the treatment of the insane where art, nature and religion were used, also music, singing, dancing, painting, and trips in polished, shiny boats to beautiful islands on the Nile." Sandwith is quoted by Dr. Bassoe as stating that, "in the thirteenth century, patients in the Cairo asylum were soothed by harmonious music and entertained by story tellers, dancing and light comedies." As humane treatment of the mentally ill developed, what is now known as occupational and recreational therapy was emphasized.

I vividly recall Dr. H. Douglas Singer's accounts of his pioneer work in the use of diversional occupational therapy as a psychiatric treatment at Kankakee State Hospital during his superintendency there in the early days of his career. His patients were taken out of wards for deteriorated schizophrenics and put into recreational and occupational therapy facilities. They became, thereby, not only better citizens of the hospital, but, in some instances, were salvaged to the extent of being able to be returned to civilian status.

Although occupational therapy had its origins in the treatment of mental disorders, it attained the status of a treatment in the medical sense as a part of a total surgical or orthopedic treatment before it attained similar recognition in psychiatry. The development of functional occupational therapy as a therapy that can be prescribed, carefully controlled, and varied to suit the anatomical and psychologic needs of the individual patient in the treatment of orthopedic and traumatic surgical patients is due to the close collaboration of occupational therapists with the surgeons and physical therapists.

It has been my privilege to observe the development of functional occupational therapy at St. Luke's Hospital under the leadership of Drs. John Coulter and Harry Mock. These men have seen the possibilities of occupational therapy as a psychiatric treatment, and I am indebted to them for their support and encouragement.

Psychiatrists, on the whole, have not been interested in developing the possibilities of making occupational therapy an exact scientific therapy within a total psychiatric treatment. Many of them are content with the contribution made by occupational therapy in bettering the welfare of the intramural psychotic patient. They continue within the historical point of view that occupational therapy is a fulfillment of humanitarian motives rather than a scientifically based psychiatric treatment. Tonight I will attempt to stimulate interest in the de-

[1] Bassoe, Peter; Spain as the Cradle of Psychiatry, American Journal of Psychiatry, Vol. 101, No. 6, May, 1945, p. 731.

Address delivered at the Annual Banquet of the American Occupational Therapy Association August 15, 1946.

velopment of occupational therapy as an independent component in a total psychiatric treatment.

In order that occupational therapy may achieve the status of a scientifically based psychiatric treatment, it is necessary that the therapist have: (1) a psychodynamic understanding of the human relationships existing between the patient and the therapist, and between the patient and the group; (2) a psychodynamic understanding of the patient's attitudes toward the art or craft to be used; (3) a psychodynamic understanding of the psychologic values intrinsic within these arts or crafts; (4) a realization that the integration of the efforts of all attending personnel is necessary in order to realize a treatment situation. With such an orientation and training program, and with a teamwork point of view, occupational therapy could be standardized as a treatment to fulfill specific therapeutic goals.

The fixed component in the treatment situation thus standardized would be the attitudes and behavior of the patient on a given day. The variables, which could be prescribed, would be the attitudes of the therapist toward the neurotic needs of the patients, or where this is not possible, the assignment of a patient to a therapist with a given personality. Variables, also, would be the selection, variation, or termination of an art or craft for the patient according to his needs.

It has become apparent that a psychodynamic orientation as to the patient's changing attitudes and behavior are essential to the successful functioning of the treatment. This is achieved by instituting: (1) staff conferences at which the occupational therapists together with all the activity workers meet with the psychiatrist; and (2) daily rounds by the psychiatrist to the occupational therapy department where he can make on the spot interpretations, explanations, and recommendations.

For years, occupational therapists working in mental and general hospitals have been intuitively aware of the twofold aspect of their work; namely, the activity aspect and the human relationship aspect. These therapists succeeded because of their intuitive ability to provide an indicated human relationship, or because they possessed personalities which fulfilled the neurotic needs of the patient. They sensed that at times a kind, patient, tolerant, sympathetic attitude was appropriate, while at other times, firmness, frustration, or non-permissive attitudes were needed. These therapists utilized a psychiatry based on humanitarian principles, intuitive feeling for human relationships, and common sense. Psychoanalysis has enlightened us as to the psychodynamics of the intuitive process. I propose that occupational therapists make use of psychoanalytic knowledge so that their results can be obtained on the basis of understanding rather than on intuition.

Every psychiatric treatment is diagnostic as well as therapeutic. Occupational therapy offers unusual opportunities for observation of the patient for diagnostic purposes, for when the patient is in occupational therapy, he is in an atmosphere where his spontaneous activity is encouraged, where he is a participant in a group, and where his work habits at a prescribed task as well as his attitudes toward play become apparent. As the occupational therapist is taught the diagnostic significance of the patient's behavior, she will develop facility in giving needed human relationships either of a spontaneous or a prescribed nature, as well as develop ability to report observations of a diagnostic character to the psychiatrist.

It will be seen, then, that by far the most important factor in the function of occupational therapy as a psychiatric treatment is the psychodynamic orientation of the occupational therapist and the integration of her efforts with those of the other activity workers and the psychiatrist. The net results of such teamwork will be a greater awareness on the part of the occupational therapist as to what she is doing so that she can become more proficient in the carrying out of the orders of the psychiatrist, and the development of an ability to relay to him diagnostic information valuable for his individual treatment of the patient. Military psychiatrists, because of the large number of individuals whom they treated, early found the usefulness of such teamwork, and in doing so further stimulated interest in occupational therapy as a diagnostic and therapeutic psychiatric technique.

In asking your consideration for occupational therapy as a psychiatric treatment, the recommendation of the utilization of the human relationship between the patient and the thera-

pist requires no justification as it is well recognized as the sine qua non of all psychiatric treatment. Also, the use of the prescription for the specific human relationship needed within a therapeutic situation has an experience background in the psychiatric nursing order, and in the psychiatrist's recommendations to employers, relatives, and friends of a patient. Limitations for this type of prescribing are to be found only in the personality rigidities of those who are responsible for carrying out the prescription.

However, the prescription of an activity for a specific psychodynamic purpose has not been so well grounded in experience. Experiments of this kind are being carried on at Topeka, Kansas, by the Menningers and their associates. Karl Menninger stated in 1942, "It is hoped that an extensive series of experiments with different types of media as an outlet for expressing the unconscious instinctual needs in different types of psychiatric problems will lead to a more effective and specific prescription of the use of Occupational Therapy." [2]

Every psychoanalyst is familiar with examples of patients who get security from their work over and above the human relationships involved through identification with the tools or machinery of work, through feelings of power encouraged through the use of these implements, and through relief from anxiety where the work involves habits or techniques which gratify the personality needs of an individual in his adjustment to the outside world. Thus, the individual who must be orderly, neat, and meticulous can find a place where these attitudes are rewarded in industry; the person who is most comfortable with careless, slovenly, messy activities also finds no difficulty in getting placed. Supporting evidence for such interpretations is found in individuals who are maladjusted in their work rather than in successfully adjusted individuals. When tensions are analyzed it is found that the work or activity engaged in had specific psychodynamic meaning to the patient.

I wonder how many of you could do a hangman's job, or slaughter cattle, or even rip open the entrails of a dead steer? I wonder if you have ever contemplated what goes on in the mind of the successful sleuth or bucket shop operator? I wonder how many of you go into a dither when the occupational therapy shop gets disorderly through all day usage and compulsively must straighten it out before leaving for home? There must be many among you who have recognized that you are more comfortable in teaching one activity in shop than another, and because of that factor, are more successful or skillful in the teaching of that art or craft.

The understanding that it was possible to relieve tension through job placement led Dr. Thomas L. Fentress and myself, while we were connected with the Veterans' Rehabilitation Center of Chicago, to make recommendations in vocational guidance and placement based on psychodynamic considerations. In this work we were assisted by Dr. Helen Shacter, chief psychologist at the Center, and Mr. Sam Handler, social worker at the Center. Fulfillment of these recommendations was successful because of their specificity, and because of our permissive attitudes.

Thus one veteran who had strong but repressed masculine strivings was enabled to have these without guilt or anxiety through appropriate job placement. His small stature did not permit the handling of a truck the size that would fit his fantasies of manliness, so it was prescribed that he be placed in a school of transportation where he could learn to route trucks and eventually become a supervisor of truck transportation.

Another veteran who had strong paternalistic impulses inhibited by deep-seated feelings of guilt and fear of what he believed to be a castrating father, following successful treatment, became a highly paid industrial engineer, a position in which he has symbolically become the critical father.

Another veteran, with high scholastic aptitude, was freed from his compulsive need to follow his father's occupation, that of a machinist, in which he was unhappy and unsuccessful, to become an outstanding student in law school.

Successful placement does not imply that there are only strong unconscious strivings toward leadership and mastery to be fulfilled. Other emotions demand equal satisfaction. In

[2] Menninger, Karl; Recreation and Morale, Subjective Symposium, Bulletin Menninger Clinic, May, 1942, Vol. 6, No. 3, p. 103.

one veteran fear of the dominating, cruel father was so great that rigid passive patterns in the patient's personality were formed. He could be comfortable and productive only if with a kind father who was not a threat to him. He broke down when confronted with what he believed to be sadistic, authoritative figures in the armed forces. Following recovery from the schizophrenic withdrawal that took place, he is making an excellent adjustment as an assistant to a kind, authoritative figure in an insurance office.

Another veteran, following his discharge from the Army, sought white-collar jobs, but after he had been in this environment for a short period, became very panicky and tense because he felt he was a softy, that these jobs were not sufficiently manly. He attempted alternately to work in heavy industries, but could not stand the noise, the dirt, or the men with whom he was in contact. Afer several attempts at adjustment, he broke down with severe panic reactions, indecision, and inability to cope with the situation. Psychiatric treatment enabled him to gain insight into the passive aspects of his personality. When he could adjust at this level without fear or tension, he found himself exceedingly happy in creative work and gardening. He is now very enthusiastic about his chosen career, that of preparing to be a scientific farmer in a school of agriculture.

Another veteran, with superior intelligence, found that his exhibitionistic impulses were so associated with castration anxiety that he could not accept leadership for which he was qualified by his knowledge and charm. Following successful treatment, he has found a position in an office where he is the power behind the throne.

Your attention was called to these illustrations at this time for the purpose of showing you that activity, even in the realm of the way one earns his living or prepares for a career, may be an effective way of solving unconscious conflicts and working out sublimations of previous anxiety ridden and guilt laden drives. It is to be noted, that in some instances, the symbolic nature of the activity to the unconscious is all-important; in other instances, the human relationships involved determine the therapeutic value of the job placement.

However, a Utopia where everyone can be in the job for which he is emotionally best suited does not exist. The vast majority of the working population is not so fortunate. However, many people, I am told the number amounts to millions, have found in hobbies another means of relieving anxiety, of releasing repressed impulses, and of circumventing deep-seated guilt feelings.

Prior to the organization of my ideas for this talk, I knew very little about the psychodynamics of hobbies. My only information had come from the study of a relatively small number of individuals with whom I had come in contact in general psychiatric practice. At this moment it is significant to me that I have seen so few patients, who had prior to my treatment of them, developed a serious interest in one or more hobbies. Perhaps the aphorism at this point should be that instead of "an apple a day keeps the doctor away," "a serious hobbyist needs not a psychiatrist."

I recall one patient under my care who had a number of hobbies all in the same vein. These were related to very elaborate statistical compilations, by the means of which he hoped to beat the markets. At one period, while he was working on his farm, he studied the dairy market with great zeal and interest. In the meantime, his cows became sick from overly distended udders. This compulsive need to work out the details of his money-making schemes forced him into unceasing action, but unconscious inhibiting influences never permitted him to try out his plan.

During the past two months in attempting to learn something about people who have hobbies and the psychologic nature of these hobbies, I visited a number of people in their homes and workshops. I learned that the trend of my patient to keep his hobby activity apart from his earning capacity is one of the characteristics of many hobbyists. It is true that in every serious development of a hobby which involves collecting, artistic endeavor, or development of a skill in a craft, there sooner or later intervenes the recognition of the value of the collection, the desire to add to the collection the highly treasured piece, or to sell the product of the creative art or craft. Yet most hobbyists agree that although one of the motivations is economic, the actual sale of objects is relatively rare unless the hobby proceeds from the stage of hobby to vocation. Often

the heirs of the hobbyists reap the financial rewards of their work.

I am reminded of my recent visit to the Midwest Writers' Conference where I heard much vigorous propaganda to the effect that writers should ask higher prices for their creative work. Is seemed significant to me that the pleasure in creative writing was sufficient to motivate the hard work necessary, and that the general response to this propaganda was observed by me to be listless, certainly not enthusiastic.

The literature on the descriptive phases of hobbies and instructions how to develop a hobby, as well as literature which has come out of intellectual development of hobby pursuits, is very voluminous. In my recent survey of the literature, however, I did not find many articles dealing with the psychodynamics of the hobbyist. For those who are interested in the deeper psychodynamics of collecting, I recommend the reading of Jones[3] and Abraham[4] on anal character, and a more recent article by Merrill Moore on Conchology.[5] The best introduction to the psychodynamics of hobbyists is an article written by Karl Menninger in RECREATION AND MORALE.[6]

For my brief study of the psychodynamics of hobbyists, I interviewed collectors, model makers, and those with recreational hobbies and creative hobbies. I was able to reach some general conclusions about the psychodynamics of hobbyists, and some specific conclusions about the psychodynamics of individual hobbyists. Common to all of the hobbyists I interviewed was a great enthusiasm in their hobby, and evidence that a great deal of time was devoted to it. There was no question about the fact that it was in their blood. Some had indoor hobbies for winter and outdoor hobbies for summer. The attitude of the husband or wife of the hobbyist was either that of encouragement and tolerance, or antagonism. In some instances the wife and the husband both had a hobby.

The collectors I interviewed all had what is called by psychoanalysts anal characters. Significant in the emotional background of the group was a predominant feeling of rejection in childhood. The psychiatric history was such that one would anticipate hypersensitivity to rejection. These people indicated that with their hobbies they were not lonely. I was surprised to find that the collection often started with articles of which there were fond memories in childhood. Common to all of the collectors was the pleasure they found in going about hunting objects, having collector items given to them by friends, and in matching sets. Also pleasurable was the ability to identify as a priceless relic that which to other persons often was a discarded object. As their hobby developed they had additional pleasure in sorting out items, classifying them, labeling them, fitting them into sets, and eventually expanding their knowledge on the subject of their collection. In so doing, the hobbyist's stature increased, and he became an authority on the subject. All seemed to be people with great intellectual curiosity who read a great deal on allied subjects, and who developed skill in recognition. They were exceedingly willing and pleased to discuss their findings. Often one collection led to another, so that there seemed to be continuous expansion.

They are a well-organized group, exchange ideas with other collectors, and trade surplus items. The collectors whom I interviewed were experienced collectors. They were aware of the value of their collections, but not particularly interested in their sale. Some of the collectors of antiques were very orderly and neat in the manner in which they displayed their collected items. Others arranged their collections in somewhat the same disorganized, careless manner as is characteristic of antique shops, keeping all articles heavily laden with dust.

A stamp collector, aged 55, a graduate of a law school, did not have what for him could be termed as satisfactory success in the practice of law or in real estate. His present employment, although noteworthy, actually does not measure up to his ambitions, or satisfy his feelings of self-importance. His collection of

[3] Jones, Ernest; Anal Erotic Character Traits, Journal of Abnormal Psychology, 1918, Volume 13.

[4] Abraham, Selective papers on Psychoanalysis, Contributions to the Theory of Anal Character, 1921, Ch. 23, pp. 370-392.

[5] Moore, Merrill; Note on Conchology, The American Imogo, April, 1942, Vol. 3, pp. 113-128.

[6] Menninger, Karl; Recreation and Morale, Subjective Symposium, Bulletin Menninger Clinic, May, 1942, Vol. 6, No. 3, pp. 103-107.

stamps is one of the best in the city. He has become a stamp collecting authority in a very large group, is greatly interested in introducing new members to his hobby, and is widely informed on all aspects of stamp collecting. He is very eager to show off his collections to others, and welcomes opportunities to make public utterances on the subject. He has a number of specialty collections, is well aware of their monetary value, is constantly alert for a gold strike, although he actually has never sold any of his stamps. The seeking and retaining of objects of value, the careful organization and systematizing of his collection, the increase of knowledge, the development of his name as an authority on the subject of stamp collecting provide a means of offsetting the anxiety about his inadequate business adjustment. It is possible that the unconscious inhibiting influences interfering with his realistic business adjustment are not present in his hobby.

One of his close friends whom he has introduced to stamp collecting is a much more passive individual; less voluble about his hobby. This man has made a financial success in a heavy industry. His work requires many dealings with aggressive people. He finds that he must take vacations at frequent intervals regardless of any work that needs to be done. Aside from deeper motives, stamp collecting is for him a passive activity. It affords him an opportunity to get away by himself and work with articles which are not a threat to him, and in a set-up where he can be master without the need to show aggression. For him the hobby is a means of relaxation, a retreat. To his friends, stamp collecting is a source of great activity and an outlet for energy.

The psychodynamics of the model builders were the most striking. A builder of model trains was a man whom I had known in private practice. He had had such great panic about his passivity that in the presence of even the slightest show of aggression he collapsed or exhibited hysterical outbursts of anger. This developed into an absolute phobic state. During the course of his psychiatric treatment, he was introduced by a friend to model-building. This had a very desirable effect on his character development which I recognized to be external to my psychotherapy. He spent a great deal of time and money on his hobby in which he was greatly encouraged by his wife. Oftentimes, following strain and tension at work, he was able to come to his workshop and feel free of tension as soon as he began to build his layout or run his trains in and out of the tunnels, little cities and switchyards he had built for them. As I watched him at this control box, which was chest high, and saw him manipulate the trains, I had the fantasy of Gulliver in the "Land of the Lilliputians," and sensed as never before the feeling of great security that this man must be getting in being the master of his world.

He took me to see his friend who had introduced him to the hobby. This man had begun his hobby during a period when he found himself developing what he thought was a nervous breakdown while engaged as a deputy sheriff, a job involving the taking of psychotic patients from their homes to the state hospital. He was a passive individual, fearing helplessness on one hand and aggressive people on the other, with a great anxiety about his aggressions. He very freely admitted the therapeutic effectiveness of his hobby, although his explanation showed no understanding of the deeper psychodynamics involved. He said the fine work enabled him to control the tremor in his hands.

I had the opportunity to visit a group of U-fly model plane builders who were engaged in the competitive sport of flying their planes for points given for their skill in manipulating them in the air. Here, again, I found a high percentage of very passive individuals who found in their hobby a symbolic outlet for their manly aggressions and an approved, accepted outlet for their competitiveness in this sport. Many of the wives were antagonistic to this hobby, and objected to the sawdust on the floor, and to the time spent in meetings and workshops. The men freely discussed their wives' hostility, when I sensed their ability to withstand this antagonism because of strength gained as members of a group.

The attitude of the wife often becomes the determining factor in the continued existence of a hobby as in those instances where the hobbyist is guilty about taking time for play, and projects this self criticism on to his wife's critical comment.

It becomes apparent that one's occupation, or hobby, may have a psychotherapeutic advantage for an individual because of the psychodynamic implications involved in the activity, or in the accessory human relationships. It is with this ideology that I approach occupational therapy as a psychiatric treatment.

The workman who gets relief of tension in his vocation has chosen his own therapy. He is happy in this therapeutic adjustment. He does not seek help from us. The hobbyist becomes a serious hobbyist because of a powerful, inward drive. The patient with a psychoneurosis has not found such a practical outlet for relief from tension although theoretically it is as available to him as to any other person. Because of the very nature of his illness, he requires psychiatric support or direction. Before we are able to direct him as to what activity he should engage in, or psychologically support him in activity, we must know something about his personality structure and behavior pattern.

It does not follow that the activity in which a patient engages with ease is the activity psychotherapeutically specific for him. It may be that activities which he may shun, such as are found in the art studio, are the ones that should be gradually introduced to him. Here our permission, encouragement and approval makes possible an outlet for creative abilities without self established taboos. In this way tensions and projected feelings about one's passivity are relieved. Some patients need to be encouraged to engage in some craft wherein an object can be struck with a heavy mallet or to engage in some destructive activities wherein they saw, plane, or file and hammer nails. It is possible that some will find their greatest relief from tension in working in activities which require careful, meticulous, orderly, systematic movements as in the printing press. With our approval, others probably need to be encouraged to do finger-painting, to be careless and mess with dirt, and to discover that this messy activity may result in an artistic creation that can meet with the praise and approval of associates. It may be that for the first time the patient learns that he can make something, complete a task, or carefully follow directions. For the psychiatrist, the activity affords an opportunity to place the patient in a tension producing situation where unconscious material can be mobilized for interpretation.

All of you have become skilled in studying the activities in your occupational therapy shops to determine what possible anatomical movements are present to correct weak or paralyzed muscles, or disabled joints. When you present a new occupational therapy activity in your scientific journals you describe its therapeutic use in a careful catalogue of movements aimed to cure or allay physical handicaps. If you are given a prescription to exercise a weak biceps muscle, without hesitation, there will come to your mind a number of suitable activities.

I wonder how many of you have so studied the activities in your shops that you could fulfill a prescription to relieve the tension of an individual who gets anxiety through his inability to be neat, orderly, systematic, and careful, of an individual who never can complete a task because of his overzealous tendency to be meticulous and exacting. I wonder how many of you have recognized that in encouraging and approving the work done by the men in ceramics you are fulfilling a psychiatric prescription for relieving tension of patients who have repressed their wishes to work with their fingers in something soft and pliable that is considered dirty. I wonder if you have recognized that the psychotherapeutic success of those who work in the jewelry shop may have come through the great pleasure they have gained from fashioning with their own hands a beautiful treasure, or that through pounding with a heavy mallet, they have shaped a piece of silver. I wonder if you are aware of the real nature of the relaxation, and the relief from tension the man who sits before the loom and works out his creative pattern gets. I wonder if you realize that photography is an art that preserves; and, in preserving, offsets impulses to destroy. I wonder if you have sensed the tension relieving results that the cartoonist may secure by a hostile attack, with your approval, on the object of his choice. I wonder if you are familiar with the fact that many of the artistic creations in the art studio have the same value as dreams, and that they not only relieve tension, but also offer important diagnostic material. It becomes apparent, then, that a very careful study of the character and nature of the work produced in the various arts and crafts

must be made not only in terms of the possibilities within a given craft, but in correlation with the psychodynamics of the individual involved.

We are now ready to more closely analyze the type of observations the therapist must be able to make to enable the psychiatrist to put the activity and the human relationship on a prescription basis. Such observations require psychodynamic orientation and emotional objectivity on the part of the therapist, for she must observe the patient's attitudes towards her, toward the group, and toward his activity. A diagnostic portrait of a given patient becomes possible on the basis of such observations.

On the patient's attitude toward his work she will be asked to record the answers to such questions as: Is the work done systematically? Is it well planned? Is it orderly, carefully, and neatly done, or is it carelessly or clumsily done? Is the patient careful or careless of his tools? Is his work delayed by excessively orderly, meticulous attitudes? Is there a stubborn, obstinate, compulsive attitude on the part of the patient, or does he permit changes, deviations, or new ideas? Is he enthusiastic, or is he bored? Does he have imagination? Does this imagination run wild, or does it develop into practical, creative ideas? Does the patient dilly-dally? Must he work on more than one project at a time? Is his attention easily diverted, or does he concentrate well?

How does the patient terminate his work? Is there evidence of feeling of pride upon good achievement? What is the patient's reaction to failure or frustration? Does he get temper tantrums, pout, fret, or refuse to do another article? Is he generous in giving away time or articles he has made, or is he reluctant to part with them? Is he motivated by the opportunity of the sale of an article? What articles does he keep for himself?

Personality traits other than those involving close relationship with the working of the tools and materials of the activity are sometimes exhibited by the patient. Here such questions as the following are pertinent: Does the patient want to show off, does he have a need to show off, does he wish to take over as a leader or teacher? Does he use very ornate colors for paint jobs? Does he select unusual projects? Does he seek to draw attention away from the instructor to himself? Does he attempt to call attention to poor work that he's done? Is there evidence of megalomania?

As to the patient's attitude toward the therapist, a careful recording of both the passive dependence the patient exhibits and his defenses against it is needed. Does the patient seek special privileges? Is he stimulated to better work by praise? Does he seek praise at every opportunity? Is he hypersensitive as to whether or not his work is thought by you to be praiseworthy? Does he have a good sense of critique in relation to his own work? Is he hypersensitive to your criticism? Does he destroy his work as it is criticized? Does he need more than the usual amount of attention and interest? Is he demanding for attention and guidance? Will the patient ask for assistance, or must this be forced upon him? Does the patient refuse to accept dependence on the therapist? Is there a compulsive need to be independent and individualistic? Is it possible for him to take suggestions? Or must he be permitted to work out his own problems?

If you are having difficulty in giving directions to the patient, you will observe whether he prefers to learn by watching others rather than taking instructions from you, or whether he goes compulsively contrary to your orders. Does he use vile and profane words when told what to do or not to do? Does he have rationalizations for his mistakes, or must his rationalizations for his mistakes be accepted? Is the patient rude and insolent? Does he try to make conversation about external things? Does he clown? Does he exhibit crude and affectionate behavior? Does he prefer to visit with the therapist rather than work? Does he try to get the therapist to do his work for him? Does he betray a bitterness toward the woman therapist? Does he try to show up the therapist, depreciate her, ridicule her, or put her in a humiliating position? Is it at all possible to guide or influence him? If so, how? Are there paranoid trends or evidence of ideas of reference which must be dealt with in your human relationships with him? Is he nonconformist? Does he break rules? Is it necessary for the patient to be the master in a situation?

Of particular interest to the psychiatrist in the formulation of a diagnostic portrait on

which to base a psychiatric prescription is the behavior of the patient in a group. The occupational therapist needs to record such observations as: Is this an easy adjustment for him? Does he clown and annoy other patients? Is he irritable and critical toward other members of the group? Is he unduly competitive? Must he be outstanding? Can he stand to be overshadowed? Does he try to dominate the group? Can he work as a member of a team, or must he be the leader? Does he welcome being engaged in conversation? Does he withdraw and isolate himself? Does he show tension when the attention of the group is focused on him? Does he invite a recreational atmosphere, or does he contribute to the tension of the group? Does he exhibit disturbing acting-out behavior when he gets exasperated? What is the nature of this acting-out behavior? Does he show an allergy to the work situation which is inconsistent with his attitudes in other departments?

There will be certain observations which the psychiatrist alone must make. These will be interpretations of behavior and of dreams which follow the use of the occupational therapy shop to relieve guilty feelings, to encourage the uninhibited expression of aggressions, or to stir up tension by stimulating repressed behavior patterns. Those of you who are familiar with the clinical course of the psychiatric treatment know that the behavior of the patient today or this week often is not the behavior of the succeeding day or following week. Psychiatric orders must be changed. In time, the skill of the therapist will enable her to adjust her attitudes to the changing behavior of the patient. As the patient becomes less dependent, she will not need to meet his demanding attitudes. As he gains insight into the source of his tension through correlating interviews with the psychiatrist, this tension will no longer be present, so that the attitude of the therapist and the work assigned to him may be changed. As the patient overcomes through insight his tension about a given activity, new activities may be introduced to him. Thus occupational therapy will become a means of psychiatric treatment with a definite goal, definite indications and contraindications, and with definite concepts as to what can be accomplished within a given time.

Tonight I have attempted to outline for you what I believe to be the necessary requirements to enable occupational therapy to be considered a psychiatric treatment. To put this idea into practice, schools of occupational therapy will have to give more intensive courses in the understanding of the psychodynamics of the personality. Close teamwork must be developed among the occupational therapists, psychiatrists, and other activity workers, and patients must remain under treatment in the occupational therapy department for a sufficient length of time to permit completion of treatment. For the latter purpose, I recommend the development of psychiatric treatment centers for ambulatory psychoneurotic patients which should include facilities for occupational therapy, and where the work of the activity therapists would be correlated with that of full-time social workers, psychologists and psychiatrists, and where the patients would be given psychoanalytic psychotherapy which would be integrated into the activity therapy.

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Rehabilitation Therapy in a Sanatorium

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In discussing any plan of treatment of the tuberculous, it must be borne in mind that insanatorium activities can not be dissociated entirely from extra-mural duties of the sanatorium. The disease affects the individual from the first infection and remains with the patient throughout life. As well as complications arising from the disease and its treatment, there are family and community implications, both social and economic, before and following hospital care, which influence the progress of the patient towards a permanent recovery. In a hospital, these complications must be considered and, if the patient is to be fully rehabilitated, be corrected or counteracted. Medical care and medical rehabilitation take first place, but just as the auxiliary services of x-ray and laboratory have become essential to the good practice of medicine, so also the auxiliary services aiming at complete rehabilitation of the patient are necessary in a good hospital program.

All hospital services overlap in time and purpose. They must be coordinated and integrated to give the most value attainable for the patient. The welfare of the patient remains of first importance and a sense of proportion must be maintained, particularly in a hospital with a limited budget, to attain the most suitable division of services. Whether these are voluntary aid of non-professional groups or the more costly help of highly trained workers, they all have value and must be considered in building up an economical as well as effective program. An understanding of the disease being treated and the rationale of its treatment is necessary to evaluate the importance of these services. This discussion is presented from the standpoint of tuberculosis of the lungs, the type of disease with which we are most concerned.

Tuberculosis, being an infectious disease, is a public health problem, its control a necessary community job. The most effective way to control tuberculosis is to isolate the infective case in an institution designed for that purpose. Sanatoria were established and are maintained at public cost for the protection of the Community. This is their primary purpose and, if isolation could be enforced, no other measure for its control would be necessary. But as people in many walks of life are involved, no effective method of compelling and continuing quarantine of all cases is available. Something more than bed and board has to be offered to persuade patients to become isolated and to remain until they are no longer a hazard. To be fully effective, the sanatorium has to be made attractive; give as much, at least, as a home can give, and offer some hope of future freedom. Also, it is now generally accepted that the disease is acquired through no fault of the patient, but rather through faulty public health measures. The Community has a duty to the patient who is being isolated for the Community's protection. For this reason, as well as for that of protection, every opportunity should be provided to help recovery from the disease and return the patient to a normal life. Sanatoria have become hospitals for the treatment of the tuberculous and their rehabilitation is a duty of the Community.

Tuberculosis is no respecter of persons. It is found in any age group or social group and in all it may be equally a hazard. The determining conditions for disease development in an infected person are the resistance of the person and the intensity of exposure, and extent of infection. Fortunately, most are highly resistant and do not develop the disease. This resistance, usually high during childhood, varies later and disease may develop at any period, though during early adult life is the most frequent. We do not know why this change occurs nor why some, although relatively few,

who previously have been immune, lose their resistance. Neither have we any measure of resistance. Nor are we able to determine who may break down. We only know that most retain their resistance. As well as this variation in immunity, there are many extraneous conditions which lower the resistance. The economic factor plays a part through its associated conditions of overcrowding and exposure, poor hygiene, and poor dietary habits. But any condition, physical or mental, which lowers the stamina of the person may be sufficient cause for the disease to develop. The sanatorium population is not one of only the down and out. It is composed of all types and classes of people. It is a fairly representative cross section of the community and the sanatorium program has to be designed to care for a wide variety of people with diverse backgrounds.

The pathological changes which tuberculosis produces vary in each case, both as to severity or acuteness of reaction and the extent of physical changes produced. It is a chronic disease, usually slowly progressive or retrogressive, with reparative processes developing simultaneously with destructive ones. Fibrosis, or scar tissue formation, is constantly attempting to wall off and replace diseased areas. It is a process of simultaneous healing and breaking down, and the ability to heal determines the outcome of the case. The extent of these changes and the progress of the disease depends upon the resistance of the individual. If this is sufficiently great and infection has not been too extensive, only a minimal lesion may result which clears with no visible after-effect, leaving only a potential handicap of possible later reactivation. This may be no greater than the potential danger of accidental injury which we all run. All gradations of destruction are found from this insignificant lesion to far advanced multiple lesions which render the patient permanently handicapped for any profitable effort. And even in the latter, activity of disease may halt and the patient die from senility. The formation of scar tissue, if extensive enough, not only replaces destroyed lung tissue but, through contraction, causes distortion of surrounding structures in the chest and, though a healing process, produces further disabilities. As well as the anatomical changes produced, there are generalized reactions caused by intoxication, the result of absorption into the system of products of tissue and bacterial destruction. Many of the symptoms and general effects of the disease are due to the intoxication, as is the intensity of the local reaction. Anything which will help to reduce absorption and prevent further destruction will aid the healing of the disease.

Tuberculosis can be cured, not only in the big majority of early cases, but frequently in the far advanced. We use the term "apparently cured" only because we have no irrefutable proof or means of knowing when, or if, the disease in any individual has become permanently healed and not merely latent. The disease is not removed by treatment. It heals by walling off the diseased areas. The tubercle bacillus is indefinitely viable. In the walled off areas the bacilli remain a potential source of later disease if conditions should arise which would give them an opportunity to reactivate. It is because of this that people who have had clinical tuberculosis must remain careful. However, we do know that the majority of people infected have had a high enough immunity to ward off any significant disease development, nothing more than a positive tuberculin reaction remaining; or if disease has developed, that they have had sufficient resistance to have healed their disease spontaneously and remained healed for the remainder of their lives. We can not say definitely that this is so in any individual case, but the medical man can make a fair estimate of the probability. This should be taken into consideration by all post-sanatorium agencies who have to do with the aftercare of the tuberculous. Many persons who have had an unrecognized tuberculous infection have been rehabilitated for other reasons without developing an eventual tuberculosis. The person who has had tuberculosis should not be damned merely because he has been found out. The diagnosis alone should not be a reason to bar him from rehabilitation service nor limit his choice of work without competent and complete evaluation of ultimate prognosis. Rehabilitation of the tuberculous should be built around the patient and not the diagnosis. It is because of this possibility of reactivation of disease that treatment is concerned with the post-sanatorium life of the patient. If the sanatorium has not done a thorough job, the patient returns in worse condition than before.

The treatment of tuberculosis is based on its pathology and the normal tendency towards healing. The majority of patients with active disease are in a near balance between healing and breaking down. The principle of treatment is to take advantage of this normal tendency and to weight the balance in favor of healing. Anything which increases resistance and aids the normal processes of healing helps to cure the disease. The aim of sanatorium care is to correct conditions which are deleterious to the patient, and obstructive to healing, and, to provide those which are beneficial. Because the sanatorium is caring for a group of individuals requiring the same basic treatment, a routine has to be established for efficiency and economy of operation. This regiments the patients. But no two patients are similar. The individual also must be considered.

Tuberculosis causes injury to tissues of the lung. As with any injury to body tissues, rest of the affected part promotes healing. Immobility is necessary for the ideal of absolute rest. Since respiration is a vital function, complete immobility of the lungs can not be attained. As, however, this function is concerned with the general metabolism of the body, partial rest for the lungs can be achieved by limiting physical activities to an essential minimum. This reduces the need for oxygen necessary in metabolism and consequently slows respiration. As well as aiding healing, this partial rest also diminishes the absorption of toxins and reduces their reactions. Rest, together with a proper hygienic and dietetic regime, is the basis of sanatorium routine.

Minimizing body activities may be sufficient to arrest disease processes in early cases or those with limited disease. In more advanced cases, unfortunately the majority, the destruction caused by disease and repair may be so extensive that it cannot be corrected by generalized rest alone. This has to be supplemented by other procedures, surgical in nature, called collapse therapy. By this collapse the lung is reduced in size, cavities are closed, diseased areas decreased in extent, and some degree of local immobility is added. This may be a temporary measure, as in pneumothorax, causing no more disability than the disease would have done. Or, as in thoracoplasty where the chest wall has to be reduced to fit a shrunken lung, a permanent pulmonary disability of more or less major extent is produced. These supplementary measures may hasten the arrest of disease activity and shorten the period of absolute rest that is necessary. But, again, the diseased tissue is not removed; it has to heal by the normal process of fibrosis. Modified rest therapy has to be continued for a prolonged period.

To secure a maximum of physical rest, mental rest is essential. The patient must be contented as well as comfortable. A disturbed person cannot rest. Peace of mind, as well as of body, is necessary. Adequate and cheerful living quarters, good housekeeping and cleanliness, all creature comforts, are conducive to contentment. Food needs to be attractively served, satisfying to a variety of tastes, as well as nourishing. Food is an item of major importance to contentment in a chronic disease hospital. Provision has to be made for religious needs, social and diversional activities, as well as for medical and nursing care. All departments of a hospital are involved in providing rest therapy. Occupational therapy has become a valuable part of treatment in all types of hospitals and all types of diseases. In some special hospitals, as the orthopedic, it may be an adjuvant to other special treatments. In a sanatorium, as in a general hospital, where the needs for other special forms of therapy are only occasional or minimal, occupational therapy fulfills most needs and frequently can substitute for these others. It is important in securing mental rest.

This routine treatment of the disease is well established and is comparatively simple, but it has become involved with the effects of the disease and treatment on the individual. In all illnesses a patient is affected to some extent physically and emotionally. To how great an extent depends upon the type of disease and the pathological changes it produces, as well as upon the peculiarities and traits of the individual. These physical and emotional disturbances influence each other and have a direct bearing on the speed and completeness of recovery. These effects of disease are important in sanatorium treatment. They also are important as they have a big influence on the future welfare of the patient. The sanatorium is involved because of its duty of protection;

protection of the individual and community from disease reactivation. Even if treatment of the individual does not take first place from the treatment of the disease, it is more complicated and difficult to control. It is complicated because of the diversity of patients involved and the variations in extent and kind of reactions produced.

In all illnesses some physical disability is produced even if it is only slight and transient. In tuberculosis it may be slight, but it has to be prolonged. It has to be prolonged because of the passiveness of rest therapy and because of the nature of the healing process. Convalescence has to be slow. Physical rehabilitation must be accomplished by graduated steps under constant observation. The physical capacity of the patient for effort can only be estimated and has to be proved slowly by trial. It should be continued to the ultimate exercise tolerance or work tolerance which the patient will need for his later activities. Whether this is accomplished within the sanatorium or without, it should be under sanatorium observation. As there is no test as to when healing is complete, artificial criteria based on the observation of capacity for physical effort over a time period have been established on which to make an estimate as to whether disease is apparently arrested, or apparently cured. Obviously this estimate can best be made by the sanatorium.

The emotional effects of the disease begin with the first knowledge of infection. Or they may have begun with a previous infection within the family. It is an infectious disease about which there is much misinformation largely detrimental to the patient. It is a chronic disease requiring long expensive treatment, which few families can afford without economic handicap to the rest of the family, or the acceptance of community help. Hospitalization separates the patient from family and friends and frequently means abandoning ambitions and future plans. In the hospital the first requirement is to impress the patient with the fact that they are a hazard to others, that they are infectious, and the duty of first importance is protection of others. Treatment makes an invalid of the patient for a prolonged period of time. As well, the disease produces in many patients a permanent handicap of some extent, which may be actual as well as potential. This handicap may preclude the patient from returning to former work, may necessitate some selective type of work, or limit physical effort entirely, leaving only mental effort available. For these changes in the life pattern most patients have had none or little training. For these, the future appears hopeless. All patients are not affected alike. Some may have no apparent emotional disturbances. Others may run the whole gamut of reactions. Fortunately, sanatorium patients are an average selection of people, similar to those in a general hospital, and their deviation from normal is not usually wide. Most can be corrected by a sympathetic understanding, an effort to make sanatorium life as nearly normal as can be done in a hospital, and by various applications of occupational therapy.

Whether the sanatorium is engaged in all phases of anti-tuberculosis work, or only in the actual treatment of the patient, it must reach out into the pre-sanatorium and post-sanatorium fields to do a complete job. The treatment of the tuberculous patient has become a branch of psychosomatic medicine. The causes of emotional disturbances are widespread and the influence of the emotions on the patient is far reaching. A large number of special workers are available in this type of therapy, some essential, others valuable. To some extent they are all rehabilitation workers, in that their effort is to help return the patients to a life of self-sufficiency.

In the pre-sanatorium field, welfare work is necessary to provide, at least, economic relief for the family, the need for which frequently is a deterent to the hospitalization of the patient. The welfare worker, particularly the medical social worker, can do much towards correcting misinformation and misunderstanding in regard to tuberculosis and the sanatorium. Also she can adjust the numerous difficulties which arise between the patient, his family, friends, and employers. In this same category is the public health nurse. Frequently the family clergyman is of help.

In the post-sanatorium field come the rehabilitation counselor, whether part of the sanatorium staff or of an outside agency, and again the public health nurse. The rehabilitation counselor is responsible for job training when necessary, and job placement essential

to the economic independence of the patient. The nurse is responsible for the sanatorium contact in the medical follow-up of the patient and family.

In the sanatorium, the needs of patients include physical reconditioning, mental and social readjustment and frequently prevocational and vocational training. These are all parts of rehabilitation. All patients have to be physically rehabilitated. This may require only the effort needed for diversional activities, or it may require the use of sustained and hard exertion to develop full work tolerance. Local disabilities are limited, usually muscular, and can be corrected by various functional treatments of occupational therapy. The other needs of the patients vary, but with all patients, occupational therapy plays a big part in their rehabilitation. With this there may need to be combined the help of others, the social welfare worker, the vocational guidance counselor, teachers and vocational instructors, librarian, and rehabilitation counselor. Through it all there has to be included the efforts of all sanatorium employees and the cooperation of the patients.

For the purpose of in-sanatorium rehabilitation, the patients may be divided into three groups, according to the time element and disease element. All patients at some time are included in the first group. They are the bed patients, similar in their needs to those in a general hospital. They include those just admitted and under observation, those under intensive rest therapy, the terminal cases, and the post-operative cases. The first requirement is the education of the patient in hygiene, hospital routine and ethics, and the creation of a friendly atmosphere. Orientation is a part of rehabilitation, is one of the first steps and should be begun before, or immediately on admission. The doctors, nurses, occupational therapists, and medical social workers play a part in this first phase. Following the stage of absolute rest, minimal activities, largely diversional, are permitted. This comes within the field of the occupational therapist and the librarian. The duties of the librarian with the patient can be assumed by the therapist. Reading material and discussions are a most useful means of contact. They give her an opportunity of observing the patients, of judging their needs and capabilities. Also this method of approach furnishes her with a means of creating interest and introducing guidance.

Guidance has to be initiated cautiously. Most people resent being uplifted, reformed or improved, or of being deliberately educated. This characteristic is marked in those who have tuberculosis. They have suffered many emotional blows and insults. They, practically all at first, are resentful and isolate themselves. They are full of self-pity and apprehension. To them their outlook is hopeless, there is no useful future. They are suspicious of all attempts at help excepting, perhaps, for that of the nurse, the need of whom is obvious. Even the doctor has to be tactful and circumspect in his approach to treatment, must first be a teacher. As with physical rehabilitation, mental and social rehabilitation has to be gradual. The desire for education, or rather increase of knowledge and improvement, must be created within the individual. This desire, however, can be stimulated. Use can be made of the natural curiosity and competitive instincts of the person and of the fundamental need to be productive. The first contact of the therapist with the patient is social. Friendliness is her greatest asset. Purposefulness is not apparent. It is because of the ease of approach, the continuity of contact, and the many devices that the therapist can use in treatment, that occupational therapy is so valuable in initiating and continuing a rehabilitation program.

The second group consists of patients who will remain permanently in the sanatorium as patients. Continued quarantine is necessary for those who have a persistently positive sputum and remain a public hazard. Custodial care has to be provided for others who, though negative, have pulmonary damage of such a degree that they are unable to find employment and are unable to be supported at home. Because of their tuberculous background and potential danger of relapse, they are not acceptable in other institutions. This group only needs whatever attention and occupation will keep them contented and busy and earn them a little money. The occupational therapy workshop or suitable jobs around the sanatorium usually fulfill these requirements.

In the third group come those patients who have graduated to modified rest therapy. It

includes all patients who possibly will be discharged eventually and are being prepared for discharge. Their needs are as diverse as the patients themselves. Among them are found all degrees of educational and social backgrounds with many types of previous employment. They range from the professional group, housewives, and others who have skills which may be used again, to students with incompleted training and day laborers who have had none. Some of these will have to be taught new lines of work, have their old revised, or have their training completed, in order to become economically independent. It is this part of rehabilitation, vocational training, which has attracted the most attention and has obscured the picture in hospitals. Rehabilitation of the handicapped, originally, was mainly one of job training. This was, and is, the function of Federal and State Agencies. But, in the sanatorium and other hospitals, it can be used for its beneficial effects on the emotions and morale of the patients.

In from sixty to seventy per cent of our patients disease has progressed so far that some form of collapse therapy is indicated in treatment. The use of collapse therapy presupposes gross destruction and a permanent pulmonary disability of some extent, sometimes as much as fifty per cent. This disability necessitates a selective form of work which usually means a skill. Many of the patients have had no training for the work they may be able to do. If they return to work for which they are not physically capable, or to competitive work for which they have no aptitude, or which they dislike, they may again break down, and return to the sanatorium in worse condition than before. The sanatorium has not done a good job.

The period of treatment is long, up to four or five years with pneumothorax. Some patients, while still receiving treatment, and who have suitable work which they can do easily, are able to return to it comparatively early, as soon as the period of physical rehabilitation is completed. But many patients have to remain in the sanatorium throughout their period of cure and until their cure habits are broken, or take the chance of relapse because of unsuitable conditions at home. Although collapse therapy may shorten the period of necessary bed rest and convert the positive sputum into a negative, healing remains slow. Modified rest and observation has to be continued. These patients are not ill and are able to engage in normal activities within limits set by their physicians. They are semi-invalids, partially handicapped physically but not of necessity mentally.

This is an important period and a difficult period in hospitalization. The patients feel well and look well. Relatives and friends, who do not understand, think that they are loafers and they themselves begin to think so. One of the difficulties is in finding something suitable for them to do, something to keep them mentally and physically occupied and satisfied. Card playing, rug making, reading of books, soon palls. Much of the time wasted or ineffectually spent could be used to advantage in some form of education, readily so if this education is along a line in which they are interested, for which they have been shown that they have an aptitude and are capable of doing. The knowledge that something is being done for them to make them self-sufficient breaks down their fears of being permanently dependent loafers, revives their hopefulness.

Even those patients, who have a high degree of skill or education and have work to which they will return, can be benefited by such a program. Their skills can be amplified, or they can be taught additional skills, or acquire a hobby. They attain a broader vision of others' lives and needs, as well as of their own capacities and capabilities. Their knowledge is increased. The housewife is a good example. From bedside crafts she can be guided into home crafts. Hemstitching can lead to sewing, repair of garments, dressmaking and even dress designing. She can be taught food values, the planning of menus, the principles of cooking, and eventually engage in the preparation and cooking of foods. By group activities she can be taught social conventions and the values of hospitality. Much of this, including housekeeping and the care of the ill, can be combined in work tolerance programs for physical rehabilitation. This training increases her talents and, by increasing her efficiency, makes her tasks at home simpler. Her future life is made easier, of wider range, and possibly more pleasant. This training is within the field of, and can be made a part of occupational therapy.

Some of the patients in this group have broken down because they were doing work which was unsuitable, was too heavy or in poor surroundings, required exposures which lowered the local and general resistance. Or, they had employment which they disliked, for which they may not have been adapted, and were unable to stand up to the strain of unequal competition. Others have become physically handicapped through their disease and treatment and will be unable to perform the work which they had done previously. For all of these, a new type of work is necessary. It has to be one for which they have the physical capacity. To do full justice to this capacity it has to be one for which they have a natural dexterity and also a desire or liking. Always the wishes and inclinations of the patient should be considered when deciding what might be a suitable and profitable line to follow. This consideration of the patients' wishes holds throughout their stay in the sanatorium, before any therapy is decided upon or procedure put into effect.

Consultations to decide upon procedures are as essential in rehabilitation therapy as they are in other therapy. To arrive at a decision as to what will be the most suitable and most useful course to follow, the opinions of all those working towards the rehabilitation of the patient must be considered. Their observations and findings have to be analyzed and evaluated, and a full perspective of the patient problem be kept in view. This can be done only by periodic conferences. As in all therapy, the opinion, the diagnosis and prescription of the physician are required first. His prognosis as to the present and future physical capacity of the patient has to be obtained. As this may change with his observation of progress under physical rehabilitation, the potentialities of the patient will have to be re-evaluated and the program may have to be readjusted. Information obtained through the social worker may throw light on the original cause of the breakdown and the present conditions and future requirements in the home. Her observations, and those of the nurses, therapists, and others, of the personal traits, the inhibitions, and ambitions of the patient, and the changes shown during treatment, influence the decision. The knowledge of the rehabilitation counselor in regard to available jobs and job training, the physical requirements of the job and working conditions, are necessary if a definite job, rather than a field of work, is to be planned. The summation of these, together with the patient's desires, may give a general idea of what the patient's requirements are. To these can be added, with benefit, the more definite findings of a vocational guidance counselor. Trained in psychology and its methods, this worker can by the use of questionnaires designed to bring out the background of the patient and by aptitude and other psychometric tests, learn much of the dexterities and capabilities of the patient. The field of work, or even the particular job into which the patient might fit, can be assumed more definitely. As well, this testing program is valuable to patients for whom job training is not considered, by creating an interest in, and understanding of, their problems. The guidance counselor can do much in initiating and directing the thinking and ambitions of the patient. By these conferences a progressive program can be formulated for each patient, composed of simply diversional activities or extending to full work tolerance and completed job training.

When pre-vocational training is considered, the services of certificated instructors are requisite, in at least high school and vocational subjects. If the sanatorium is located in a state or district where the local education system can be used, the education of the patients is automatically cared for. But if, as in New York State, no provision is made for in-sanatorium training by either the State Department of Education or its Rehabilitation Division, arrangements for this service must be made entirely by the sanatorium when located outside a local education district. Unfortunately, many types of work, and post-sanatorium training for these, require high school certificates. Patients can receive no credit for work done in the sanatorium unless previously enrolled in a local high school. This lack of State aid is a handicap to the patients and a disadvantage to the sanatorium. The sanatorium has no means of taking advantage of the Federal program for rehabilitation. As the needs of the patients vary continually, not only full time but part time teachers may be necessary. Patients who are qualified teachers can be employed,

with advantage to their own rehabilitation. Besides these instructors, various sanatorium departments can be used to teach vocations, as well as for the development of work tolerance. Frequently, the training for a vocation can be completed without the after help of the State Department of Rehabilitation.

Such a rehabilitation program has to be coordinated and directed. The most difficult and vexatious question to decide is who should be the director. To be successful, the person has to be one who has the interests of the patients at heart. It should be some one with organizing ability, an understanding of patients, and wide knowledge of their needs, capable of leadership and of inspiring teamwork. A technical knowledge of any of the specialties used is not necessary, though it might be an advantage where personnel is limited and other duties could be assumed. The selection may depend upon who is available and best suited for the job, as well as upon the type of hospital and the type of specialty that is of most use.

In Niagara Sanatorium the director of the adult program is an Occupational Therapist. With occupational therapy fulfilling most of our needs, the other services are amalgamated with the Occupational Therapy Department and it is named the Department of Occupational Therapy and Rehabilitation. Occupational therapy is any activity prescribed and guided, and these activities are prescribed and guided, to aid the recovery of the patient. In using them, the therapist is not intruding in other fields. In leading a group book discussion, or teaching music, she is not usurping the job of a librarian nor a music teacher. Nor is the sewing instructor, teaching a craft, or the boy scout, teaching knot or fly tying, usurping the prerogatives of the therapist. They are merely adjuvants, as is the Grey Lady to the graduate nurse. They not only help the patient, but also may teach the therapist a new device. In our children's program, Occupational Therapy is used as an adjuvant. The needs of children are different from those of adults. They have not yet been fully developed. Rehabilitation is only medical. Their handicaps are mainly orthopedic, or other physical defects, which require physiotherapy. Education is formal, and, being that of the grade school, comes under State supervision. They have to be matured in self-control, performance of group activities, and an appreciation of correct social behavior. They require direction of their play and other activities. A physical director best fills their needs.

The sanatorium is a community in itself, a small village with a special problem. We, practicing medicine in the sanatorium, are allied to the general practitioner or family doctor. The patient with tuberculosis is subject to any of the ailments of others. We have to be able to diagnose and treat most of them. For special conditions beyond our skill we are dependent upon consultants, as is the family doctor. Unlike the family doctor, we are not dealing with family groups. We are caring for a group separated from their families. We have to provide a substitute for the family to give a sense of reality or touch of home. For this, we are dependent upon the accessory staff. But, they too may be limited by scarcity of workers or, more often, for economic reasons. They have to substitute or depend upon consultants. Fortunately this is practicable. The vocational guidance counselor with her training is able to substitute, within the sanatorium, for the medical social worker, and here again the family clergyman or sanatorium chaplain can help. This counselor can consult with Welfare Case Workers on outside problems, and the rehabilitation worker doing field work can consult with and give her advice on jobs and job requirements. Or, a rehabilitation counselor, with training in patient psychology, can substitute for the guidance counselor. The occupational therapist, with her broad training and knowledge of patients, can fulfill to a large extent the requirements in many specialties.

Except for the medical correction of physical disabilities, rehabilitation of the patient is mainly one of education. Education is not merely job training. It is the training of the individual to fit understandingly and usefully into a complex society of diverse individuals. As our patients have defined it in their association constitution, the purpose of rehabilitation within the sanatorium is to help people with tuberculosis to become healthy, happy, useful citizens.

How Shall Occupational Therapists Be Registered

1. THE WRITTEN EXAMINATION

By HYMAN BRANDT, PH.D.
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The current educational research program of the American Occupational Therapy Association has as its objective the development of valid and reliable instruments for the selection and registration of those who are currently completing their academic and student clinical training in authorized and duly accredited schools of occupational therapy. To achieve this objective, it is necessary to obtain pertinent and specific answers to three questions:

1. What basic background (knowledge, skills, techniques, procedures, etc.) should an occupational therapist acquire from her didactic training?

2. What proficiency (in terms of applying her basic background to patients) should an occupational therapist acquire in her student clinical training?

3. What personal and social qualities are essential for the establishment of successful therapy with patients as well as good intra- and inter-departmental relationships in hospitals and institutions?

It is rather evident that specific answers to the above questions can only be obtained by canvassing the field and finding out what each school and clinical training center is doing currently. The Education Office has, therefore, instituted a series of surveys which are designed to secure the basic information as accurately, speedily, and economically as possible.

The information to be obtained as a result of current and future surveys is basic to the evaluation of training in occupational therapy. For, the development of instruments to measure the success of that training is but the third step in the process of evaluation. In order to measure, one must know what he or she is measuring. In the first place, it is necessary to have a clear idea of those characteristics and abilities which make a person a good occupational therapist. Secondly, if all are agreed as to what a student must be and must know to make her a good or successful therapist, it is necessary to specify the training, both academic and clinical, which that student has received at both the school and the training center. Then and only then, when the objectives have been specifically defined and the instructional program (devised to achieve those objectives) ascertained can proper measuring instruments be designed. These instruments will, of necessity, test the training directly and the objectives indirectly.

The starting point of the present program was the curriculum,* both in the schools and in the training centers. This was done advisedly since the greatest urgency was expressed about revising or building a new written registration examination. Furthermore, the American Medical Association had laid down a minimum set of essentials for the school curriculum whereas the training center curriculum had not been as clearly specified nor controlled. Since the mere perusal of course titles listed in catalogs would yield very little, it was decided to ask each accredited school of occupational therapy and each training center to submit detailed factual outlines of all courses given to their students.

It is wise, I believe, at this point to digress and explain the reasoning behind the request for detailed, factual course outlines. Fundamentally, measurement assumes the existence of a trait which is "pure" and can be measured to the degree to which it exists in a given individual. In this case, the basic question is, "What does a prospective occupational therapist have to know in order to become a good practising occupational therapist?" This represents the ideal and presupposes that there is a carefully and thoroughly developed curriculum which is common to all the schools. Since it is recognized that no such condition exists at present, the question must be changed as follows:—"What is the common body of knowledge, skills, procedures, techniques, etc., taught to potential occupational therapists at present?"

*Although the program is far-reaching, this article will cover only the development of the written technical examination in occupational therapy.

Thus, the practical criterion becomes the materials of instruction taught universally throughout all the schools and training centers. In short, the examination must test what the students have actually been taught and not what the students should know ideally. There must be equal opportunity for each student to have learned the subject matter content present in the examination. Only if there has been approximately equal opportunity for acquiring the knowledge tested, can differences in scores on that examination be indicative of the varying degrees of technical knowledge and proficiency possessed by the examinees. Then, and only then, is a valid registration examination possible.

The examination to be used for the purposes of registration must not only be meaningful (valid) but must also possess other desirable characteristics of scientific measurement. It should be objective so that everyone is rated identically regardless of who is doing the rating; there must be one, and only one, set of correct answers. The test should be reliable (accurate) in the sense of yielding approximately similar results when used repeatedly. It should be sensitive to the point of yielding as fine degrees of discrimination as are deemed necessary to differentiate the individuals in the group being tested. All of this adds up to the conclusion that a test is not merely a set of questions thrown together any more than a scale is a set of springs or a thermometer a tube full of mercury. To justify its use, the registration examination must be very carefully planned in advance; it should be "blueprinted" in the light of precise specifications.

What are the specifications? First of all, what is the purpose of this examination? It is to select the best of those who have just completed their training in occupational therapy. It is also an evaluation of what the student should have received as a result of undertaking this particular program of both academic training and clinical practice. Secondly, what are the principal sources used in planning this examination? Since this is an achievement test designed to evaluate a training program, the only logical source is a thorough course analysis. In addition to gathering all the course outlines, lesson plans and specific textbooks and other publications used in the classroom or training center, qualified experts were chosen in each of the important specialties to collate and evaluate the material and prepare the subject matter content of the examination.

The planning phase of the examination is so important and too often, sadly neglected that I believe it advisable to discuss this phase in detail. Having taken the basic position that this examination must evaluate course content, the Education Office, as previously mentioned, requested course outlines from schools and training centers. The response was varied depending upon the types of courses. Whatever material was sent in, was turned over to the specialist in that area. It should be mentioned at this point that, for the purposes of the coming examination, the following areas were assigned to participants:—(See next page)

Every participant was asked to collate all the materials—outlines, texts, bibliographies—in her specialty and to extract the necessary elements from which to construct a master outline of her specialty. The master outline was to be constructed with a dual purpose in mind. It was to furnish as complete coverage of the field (i. e. arthritis) as was known and *practiced* to date. This would be the basis for the curriculum guide in that specialty. Then the participant was to indicate specifically those portions of the field which were at present being *taught* by most of the schools. Thus, this outline furnished not only the specific content of the examination but also the basis for future curriculum revision. In this manner, training and measurement go hand in hand, as they should. The results of measurement furnish the scientific data for suitable appraisal of present status and point toward the direction in which the best progress may be made.

After the major headings or significant subdivisions of each specialty were decided upon by each participant, they met in a group to decide what was the relative importance of their specialty in the total picture, labeled occupational therapy. This was necessary since it is readily understood that all possible questions cannot be asked on an examination, but that the questions asked are a sample that must be representative of the entire field. Again, this representativeness is obtained by careful planning. We must be sure that the entire

Area	Science Background	Clinical Subjects	O.T. Applications
Orthopedic, Surgical & Neuromuscular Conditions	Anatomy Physiology Kinesiology Neuroanatomy	Orthopedics Neurology	To physical injuries
Arthritis	**********	Arthritis	To arthritis
Cerebral Palsy	Neuroanatomy	Cerebral Palsies	To cerebral palsy
Tuberculosis	Anatomy Physiology	Pathology	To tuberculosis
Cardiac Conditions	Anatomy Physiology	Pathology	To cardiac conditions
Rheumatic Fever		Pathology	To rheumatic fever
Visual Disabilities	Anatomy Physiology	Pathology	To visual disabilities
Hearing Disabilities	Anatomy & Physiology	Pathology	To hearing disabilities
General Medical & Surgical Conditions	Anatomy & Physiology (not covered in other areas)	Pathology	To general medicine & surgical conditions
Pediatrics		Pathological Conditions (not covered in above areas)	To pediatric conditions
Geriatrics		Pathology	To old age
Neuro-psychiatric Conditions	Psychology Psychiatry	Pathology (not covered above)	To neuropsychiatric

Skills (from the standpoint of both Technical Knowledge and Application to Occupational Therapy)

Design	Bookbinding	Minor crafts
Leather work	Woodcarving	Needlecraft
Textile Decoration	Jewelry & Metal work	
Woodwork (including Mechanical Drawing)	Weaving Ceramics	Recreational Activities

Orientation to Occupational Therapy—Organization & Administration of an Occupational Therapy Program
Agencies concerned in Rehabilitation and the Occupational Therapist's place in the coordinated program

field of occupational therapy is defined, that all the major areas are identified as was done by listing the specialties outlined on p. and that every one of these areas is outlined in complete detail. Then the proper number of questions can be allocated in accordance with the weight that area bears to the total field. Decisions were reached and judgments were rendered as to the relative weights of the disability fields and of the skills and then of each disability field and each skill in the examination.

As soon as the participants agreed as to the number of questions each one was to prepare for the test, the next question that arose was what subject matter in her own specialty should appear in the test. The participant then went through the same process stated above, only this time she made the breakdown in her own specialty as if that were the total test. She decided that a particular area in her specialty was worth 30% of the total, whereas another area might only rate 5% or 10%. When determining the relative weights, the participant had the dual problem again of assigning to each area the proper amount of questions to provide ideal coverage of the field and of distributing the approved number of test questions over those areas of the specialty

which were common knowledge to the student. Thus, questions were not only prepared for the coming registration examination but a reserve pool of questions is available. This reserve pool is to be used not only for future examinations based on the present curriculum but also for examinations based on expanded curricula as instruction in various specialties is incorporated in future student training.

All of the various stages in planning described thus far were completed before any participant wrote a single test question. The detailed planning—course analysis, development of detailed master outlines and allotment of questions to each specialty in terms of its importance to the entire field—was necessary, I repeat, to insure complete and representative coverage of the field, as well as meaningful content in the examination. Thus, the second phase of test construction; that is, question or item writing, is dependent upon the planning phase.

Item writing may again for the purposes of discussion be divided into two aspects, item content and item structure. Item structure refers to the actual form in which the item is written. It is not germane at this point to launch into a lengthy diatribe on the relative merits and demerits of the various forms of items now used in various examinations. Suffice it to say that the multiple choice form has demonstrated its flexibility and superiority to most, if not all, the other forms. Skillful employment of language will enable a test constructor to tap all sorts of psychological processes such as the determination of purpose, cause and effect, difference and similarity, association, degree of error, common principle and manner of arrangement, to mention but a few. The multiple choice form can measure concepts, the application of principles, and the employment of knowledge and procedures in emergency situations if the questions are properly phrased. In short, the multiple choice form offers a direct challenge to the test constructor's ingenuity.

Which brings us back to the item content. For, the content of the items will determine the success or failure of the test. There are several basic principles which help a subject matter expert select the examination content from the detailed master outline which has been prepared previously. First and foremost, the items must contain material which is basic to the field of occupational therapy and can only be answered by occupational therapists. If a question can be answered by a layman on the basis of general information or common sense, it has no place in the test, since it does not tell you anything about the knowledge possessed by an occupational therapist. Secondly, the items must contain subject matter which is common knowledge to all occupational therapy students and not so specialized that only a few highly selected experts would know the answers. Thirdly, the knowledge tested must be such that possession of it is essential for the practice of occupational therapy and not something which may contribute solely to enhance an individual's cultural background. Bearing the above in mind, each participant was asked to select suitable material in her specialty and write a requisite number of items. In doing so, she was asked to observe other precautions such as making sure that the items were thought-provoking rather than calling for mere scraps of information. Above all, she was to obtain an affirmative answer to the fundamental question —"Are students who answer this question correctly better occupational therapists than those who do not?" It went without saying that every item was to be carefully checked as to accuracy. Only that material which represented authoritative thought as expressed in publications in current use in the schools was to be incorporated in the test items.

The foregoing has been a brief attempt to relate the steps taken in the formulation of a valid written registration examination. All that the planning and item writing have sought to accomplish is the development of an examination which will insure complete and representative coverage of the outstanding material in the field of occupational therapy. Furthermore, the test content is such that every graduate from a school of occupational therapy has presumably had an equal opportunity to learn and absorb this material. The test will thus measure the degree to which she has succeeded in making this material part and parcel of her tools and equipment for the successful practice of occupational therapy.

A PROGRAM FOR PARAPLEGICS

By MARGARET S. ROOD

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The incidence of paraplegia, paralysis of the lower extremities due either to total severance of the spinal cord or pressure upon it, is rare in peace time. The experience with paraplegics in World War I and II has provided such favorable progress in results that present treatment by skilled specialists should be given recognition. Practically all of the approximately 1400 cases were salvaged in World War II as opposed to the World War I record: "80% of the soldiers died before reaching the boat, most of the others on the boat back and the handful left had from six weeks to two years of life."[1] A prolonged and useful life now is possible due to early care, blood plasma, and advanced knowledge of better ways of fighting infection.

Spinal cord injuries were of two types, the vertebral fracture with compression or severance of the cord, and wounds penetrating the cord. The former were usually splinted for three months, while the latter rarely required plaster splinting.[2] If the cord has been bruised the patient may suffer intense burning sensation referred to as causalgia. Spinal block has relieved this in most cases. Severing of the nerve has been a final result for only the most stubborn cases. Mass reflexes causing spastic deformities have been relieved after prolonged care by an operative procedure known as rhizotomy[3] which results in flaccid paralysis. The nerve roots are severed or split to allow the return to normal position. Curare has been used in some hospitals for spastic paralysis of this type.

For the patient who has loss of sensation and mobility of the lower trunk and legs there are a number of problems. The lack of sensation and continued pressure over bony prominences causes decubitus ulcers. Surgical excision may be necessary before healing can take place. Nutrition, protection of bony prominences, changing patient's position every two hours, keeping bed linen taut are other means of prevention and care. The Stryker frame allows easier handling of the patient. At Thomas M. England General Hospital, a new treatment for bed sores was used which included the use of sugar and penicillin.[1] Control below site of the lesion, bladder and bowel control are lost. Bladder infections are lessened by constant care consisting of some form of tidal drainage, irrigations and extreme care in the sterilization of all equipment. Training the patient in bladder and bowel control lessens the possibilities of skin irritation.

In tidal drainage or automatic bladder, a certain number of drops of an antiseptic solution are forced into the bladder which when full causes the bladder muscles to contract while the sphincter muscles relax, emptying the bladder automatically. In this way the muscles are trained to act and there is again muscle tonicity with gradual increase in capacity. The paraplegic must learn to gauge voiding time so that he may have freedom from embarrassment.

The danger of renal or bladder calculi forming has been lessened by getting the patient up in a wheelchair and having him move around as soon as the fracture is healed.

PSYCHOLOGICAL ASPECTS

The psychological aspects are of paramount importance in the rehabilitation of the paraplegic patient. The long slow process will require all the patient's determination and desire to improve. Unlike the amputee, the paraplegic has his limbs and with them the eternal hope of recovery. To him, pain is welcome since it may indicate "the return."

[1] Stavis, Barrie—"We Will Walk," *Saturday Evening Post*, Mar. 30, 1946

[2] Munro, Donald, M.D. "The Rehabilitation of Patients Totally Paralysed Below the Waist." See Bibliography.

[3] *War Dept. Technical Bulletin. TB MED 162* "Convalescent Care and Rehabilitation of Patients With Spinal Cord Injuries." War Dept., Washington, D. C. May, 1945.

[1] Stavis, Barrie—"We Will Walk," *Saturday Evening Post*, Mar. 30, 1946

With the time period lengthening since injury, changes in attitude toward disability must occur. The excellent article on "Psychological Aspect of the Paraplegic Patient"[1] gave the duration of illness at the time of the study as from 3-27 months. A paper is being completed at Birmingham Veterans Administration Hospital at this time which will consider attitudes of the patient now. I am indebted to Miss Frances Weiss, Medical Social worker for the Paraplegic Service and to Miss Faye Burns of Birmingham Veterans' Hospital, Van Nuys, California for much of the following material.

There is a strong attitude of hostility in most of the paraplegics, less in the enlisted man who feels he let himself in for it than in the drafted man. Resentment of authority is present as is negativism. The social workers feel that their rapport with the men is bettered by not wearing uniforms. With negativism such as this there is the question of raising the barrier higher if occupational therapy is required of the patient. The therapist should work persistently to stimulate interest and voluntary cooperation.

Loss of bowel and bladder control and sexual power shames a man unbearably. A future with emotional, social and vocational instability appears as a bleak future to him. There is anger and irritability at effortful tedious progress. With dependence and frustration is it any wonder that he needs help in developing a better outlook?

There are some, of course, who go to the opposite extreme of hostility with complete acceptance. All develop a growing dependence which must be fought from the beginning. Often this is not recognized by the patient himself. The hospital is a dependable refuge for the patient; he has no plans for the future except for wishful thinking. Of a survey of 60 patients who could now go home, only 15 wished to go. This may be due to any or all of a number of reasons:

1. Sheltered life—ramps, recreation, no decisions, group living with like handicapped.
2. Adjustment difficulty at home—physical, emotional, social, vocational and economic in a situation with constant reminders of what he used to be.
3. Expense of living at home.
4. Question—"Will I continue to get full compensation if I do get a job? Why work when I get enough?"
5. Necessity for assuming more responsibility in home or larger area.
6. Loss of much of independence due to over-solicitous family or community.

With so many problems to overcome everyone in contact with the patient must help in developing him to face his future and be willing to work to make it a more satisfactory one.

The Team

The succeeding schedule lists the component parts as shown at Birmingham Veterans' Hospital at a seminar on November 4, 1946. At certain stages there may be more emphasis on one service over another:

Class III — Bed Patient—occupational therapy, education, recreation, physical therapy and finally a light form of corrective physical rehabilitation.

Class II — Wheelchair Patients—physical reconditioning, physical therapy, eventually education and occupational therapy.

Class I — Walking and Independent Patients—emphasis is on education and vocational retraining. Walking, physical recreation and outdoor activities are second place followed by diversional and occasional vocational occupational therapy.

The medical social worker has an important and well-known part from admittance to discharge.

The patient is a whole man and an individual to be given the best possible total treatment by an integrated program adjusted to his individual needs.

Medical Rehabilitation Division of the Birmingham Veterans Administration Hospital:

Chief, Medical Rehabilitation and Physical Medicine

Executive Officer
- a. Brace Shop
- b. Vocational Advisement

Administrative Assistant
- a. Physical Therapy
- b. Occupational Therapy
- c. Educational Retraining

[1] Thom, D. A. Col., M C A U S, *North American Clinics*, May, 1945

d. Prevocational Training
e. Corrective Physical Rehabilitation

A specialized program for each
a Paraplegic
b. Orthopedic
c. Neuropsychiatric Neurology
d. Tuberculosis
e. General Medical and Surgical

Occupational Therapy for Paraplegics

Occupational Therapy is but a small cog in the total integrated program to assist the patient in the best possible psychological, social, physical and vocational adjustment to living in a normal environment world.

The therapist should be attractive preferably but more specifically she should be sweet tempered and not easily depressed. The extremes of irritability, false cheerfulness or excessive sympathy must be avoided. Turnover of personnel or shifting of services which is usually stimulating professionally to the therapist, is poor policy on the paraplegic ward or in the shop since the rapport so slowly gained will take time to be rebuilt between the therapist and the patient. Arts and Skills or similar programs may be used if the personnel is assigned regularly. Student training, because of frequent change, is not wise for the paraplegics unless the student is assigned for a sufficiently long period.

The shop, since it will need to accommodate wheelchairs, should be well planned for floor space and equipment. The majority of army hospitals had advantageous physical plants for paraplegics due to the one story construction, sheltered ramps and lack of steps. The shops should be centrally located and easily accessible. Power tools are good but should be placed lower than usual and allow space for wheelchairs and feet. Metal typing tables with locking wheels will hold many things and can be moved easily to a new position as well as pushed out of the way when not in use.

Since the large open ward is preferable for stimulating participation of the paraplegic, it has the same advantage in selling O. T. activities. Time with the paraplegic is needed more than the nature of activities carried on by upper extremities in another type of ward demands.

Of prime importance is the reaction of the patient to the activities. Records should be kept which are accessible to the doctor, medical social worker and others on the team. Complete records are kept on attendance and articles completed but too little is recorded by or requested of the O. T. concerning the patient's attitudes, aptitudes and ability, reasons for or for not wanting to engage in an activity, comments on his problems which are voluntarily aired during work period, his work habits, attention span and the like.

Hostility is an important factor in the majority of the transverse myelitis cases. What type of activity could the O. T. give for releasing this? Might not wedging lumps of clay, jamming lumps of clay mixed with excelsior into molds for lamp bases (firing burns out excelsior and leaves a lighter product with odd texture), metal work, wrought iron or hammering large bowls and plates or printing with the heavy hand press be an outlet? Other activities might be:

1. Baseball throw at canvas backdrop with milk bottles (rubber) or at bells.
2. Dart games.
3. Punching bag.
4. Tests of strength
   Strike with mallet to ring gong. Platform for striking would need to be higher than the carnival ones and patient would need to be strapped to seat.
5. Quoits. Hook to pick up horseshoes.

Many of the lighter activities will prove excellent avocational or perhaps vocational pursuits following discharge. Too, there will be a certain small percentage of high cord injuries with impairment of the upper extremities. The activities are chiefly for hand and wrist involvements. Clay work and finger painting have been used in the early stages with advancement to cord knotting and weaving for finger dexterity.

I am told that the most popular crafts on the wards at Birmingham General Hospital, Van-Nuys, Cal., are leather work and copper tooling, followed by woodwork and plastics. Shop crafts there consist of jewelry, leather carving,

plastics, ceramics, shellcraft, weaving and minor crafts.

Since the social life of the patient will be restricted on his return home, effort should be made to develop certain skills. Has he any musical ability? Would he be interested in increasing his facility or learning to play the piano, accordion, marimba or other instrument? Does he play bridge or chess? Bridge tournaments might be held for the ward with duplicate boards. Could some conjuring tricks be taught? A special skill can be a balm to the ego.

The O. T., working in close conjunction with the doctors, medical social worker, psychologist, educational and vocational advisors and trainers might be able to do better long range planning by prevocational work with a definite goal. The longer the patient turns his thoughts from partial or total self-sufficiency the greater his dependence on the sheltering hospital and the less his desire for meeting the outside world on its own terms.

The doctor, directing his team, will be the final judge of what is best for the individual patient. For this he needs all the information concerning the patient and suggestions from the therapist concerning modalities in her field. Perhaps some suggestions I have made overlap into another field or into the province of another member of the team in certain set-ups. In other places there will not be sufficient personnel so that those who are available must do as well as possible under the circumstances for the best interest of the patient. Whatever the arrangements, the problem is worthy of the maximum effort of the therapist.

The Future of Occupational Therapy in the Army

By H. Elizabeth Messick

Chief, Occupational Therapy Branch, Surgeon General's Office

The future success of occupational therapy in Army hospitals will be largely dependent upon the ability to maintain the high standards attained during World War II. The plans of The Surgeon General for reorganization of the Medical Department of the Army include the maintenance of occupational therapy in Army hospitals on a permanent peacetime basis. The only way in which it can be assured that occupational therapy will be maintained permanently is to make the personnel a permanent part of the Army Medical Department. To this end The Surgeon General directed that an Occupational Therapist Corps be created giving permanent commissioned rank to occupational therapists in the Army together with Nurses, Dieticians and Physical Therapists. This measure was approved by all concerned and the bill to establish the Army Nurse Corps, the Dietitian Corps, the Physical Therapist Corps and the Occupational Therapist Corps in the Medical Department of the Regular Army and the Officers Reserve Corps was introduced in the Senate on 26 July, 1946, as S.2481. The same bill was introduced in the House of Representatives as H.R. 7168. In addition to the Regular Army Corps this bill provided for the establishment of a Reserve Corps for each category similar to the Reserve Corps now in effect for other branches of the Army. However, with the adjournment of the 79th Congress, this bill was tabled. It will be necessary for the bill to again be introduced before an enabling law can be passed.

The bill provided for an authorized strength in suitable proportion to the total authorized strength of the Regular Army. Until the strength of the peacetime Army is determined, therefore, the actual strength of the Corps will not be known. Appointments to the Corps were to be in the grades of Captain to Second Lieutenant, inclusive, with a limited number of officers in the rank of Major, appointed by selection. Determination of rank to be made on the basis of age, experience and service. Permanent rank would entitle nurses, dietitians, physical therapists and occupational therapists to the same benefits enjoyed by male officers

including allowance for dependents, disability and longevity retirement privileges, commutation of quarters and leave benefits.

Primary application for the Occupational Therapist Corps would be open only to occupational therapists who were employed in the Army during World War II. Other applications would be accepted if the authorized quota for the Regular Corps could not be filled from this group. *Following the period of integration,* occupational therapists making application for commission must be between the ages of 21 and 26, be college graduates, and graduates of accredited courses in occupational therapy.

The requirements for application would be:

1. Graduation from an accredited school of occupational therapy and certificate of registration by the American Occupational Therapy Association.
2. Physical and moral qualifications of an officer.
3. No dependents under (14) fourteen years of age.
4. Ability to pass designated measurements of professional qualifications, such as (a) Standard knowledge test, (b) Technical examination in occupational therapy, (c) Personality analysis, (d) Personal interview.

In order to give you a bird's-eye view of events leading to this decision to commission occupational therapists, it seems significant at this time to trace briefly the development of occupational therapy in the Army.

In World War I occupational therapists were known as "Reconstruction Aides." They were recruited for the most part from the teaching field of arts and crafts and were given courses of approximately three months. The program in military hospitals at that time was organized under the Education Officer.

Following World War I, the work continued, although on a smaller scale. Courses in occupational therapy were established at Walter Reed General Hospital. With the establishment and development of the original schools of occupational therapy, the emphasis in curriculum of the Walter Reed courses changed to post graduate training and only students who had completed courses in the recognized schools were accepted for the courses. The last such course of nine months' duration was completed in 1933. The Economy Act of this same year abolished at that hospital not only the training courses but all except two occupational therapists. Likewise, due to lack of funds, occupational therapy programs and personnel in all permanent Army hospitals were reduced to a minimum. Hence, when the Pearl Harbor disaster occurred in December, 1941, occupational therapy in the Army was practically extinct.

Early in the war, the Surgeon General's Office requested the National Research Council to assist in the planning of occupational therapy programs for Army hospitals. The National Research Council in turn requested assistance from the American Occupational Therapy Association and a committee of the Association, known as the War Service Committee, was established. There were two subcommittees appointed; one to make a survey to determine the availability of qualified personnel and another to determine the needs for equipment and supply. During the next two years this committee worked with the National Research Council in an effort to meet these objectives.

On 10 April, 1943, Lt. Colonel Walter E. Barton was assigned to the Office of The Surgeon General as an assistant in the Neuropsychiatry Consultants Division. One of his major duties was that of establishing an occupational therapy service for the Army.

It had been determined by this time that occupational therapists would not be military personnel and that occupational therapy activities would be confined to the Zone of the Interior, due to the apparent shortage of personnel. Standardization of equipment and supply for occupational therapy was established and the first such list was published in September, 1943. This list contained 378 items and was incomplete in many respects. It was subsequently revised and enlarged to include 811 items and is at the present time undergoing a second revision with a view toward making it complete and applicable to a peacetime program. Concurrently with this effort plans were developed for new construction and for the remodeling of existing buildings to provide the necessary facilities for workshop space in hospitals.

Recognizing the need for a professional person in the Surgeon General's Office, Colonel Barton, shortly after he assumed his duties there, requested that an occupational therapist

be assigned to direct the development and expansion of the program that had been started. On 18 November, 1943, Mrs. Winifred C. Kahmann, Director of Occupational Therapy and Physical Therapy at the Indiana University Medical Center, and then Chairman of the War Service Committee of the American Occupational Therapy Association, was appointed as Chief of the Occupational Therapy Branch, Office of The Surgeon General. At this time there were 43 occupational therapists on duty in thirty Army hospitals in this country. Recruitment was still the most important need as the Army program rapidly expanded. It soon became evident that occupational therapists would not be available in sufficient numbers to staff Army hospitals as well as continue to give service in other government and civilian hospitals. Authority was therefore requested for the establishment of a subsidized training course. With the receipt of approval for such a course, arrangements were made for its establishment in collaboration with the American Occupational Therapy Association and the accredited civilian schools. Graduates received the diploma of the school with which they affiliated. The details of this training will be presented at this time by Miss Wilma West, who for the past two years has served as Assistant Chief of the Occupational Therapy Branch, Surgeon General's Office, and has been largely responsible for the direction of training programs.

(To be continued in the next issue)

HELP FOR THE NEWLY BLINDED

By MARY DRANGA CAMPBELL

Members of the nursing profession and occupational therapists will play an important part in the rehabilitation of those individuals who may be injured while in war service. Theirs will be the privilege and opportunity to inspire courage and confidence in the visually handicapped as well as those suffering from other injuries whether received in war efforts or in civilian life.

There are two groups of newly blinded adults: those to whom loss of sight is the only handicap, and those in whom the cause which produced blindness has also produced other physical disabilities. Unfortunately there are many in the latter group and this makes the problem of the newly blinded adult very difficult. Blindness with a strong body and unimpaired mind is one thing; blindness plus shattered nerves and a weakened body and serious physical ailments is quite another problem.

The first step, therefore, should be to eliminate the handicaps of other than blindness, whenever possible, and then help the individual man or woman to be as nearly nomal as possible. By their approach to blindness the nurse and occupational therapist may advance or retard the individual's adjustment to his loss of sight.

When the ophthalmologist is convinced that the loss of sight is permanent and that nothing further can be done to improve or restore it, then the patients should be informed, tragic as it may be, so that his rehabilitation may begin without unnecessary delay.

An ophthalmologist of national reputation writes, "In dealing with a patient one should always tell the truth. It is neither necessary nor wise in every case to tell the whole truth to the patient, but it is imperative that the relatives or near friends know the facts." Any lack of frankness causes loss of confidence, and in desperation the individual feels the night settling down upon him and flies from one source to another in the vain hope of relief. If the recognized and dependable ophthamologist fails to enlighten him as to his degree of vision, he turns to the unscrupulous and ignorant quack who offers encouragement through spurious literature and advertisement, which only increases the patient's disappointment and unhappiness when inevitable blindness comes.

Let us assume that the newly blinded person

FROM: Mary Dranga Campbell's "Help for the Newly Blinded"—American Journal of Nursing, Vol. 42, Number 11, November, 1942, Pages 1284-1287. By permission of The American Journal of Nursing.

has been informed that his loss of vision cannot be improved or restored. When this decision is reached in the hospital, then the nurse's opportunity comes to exercise all the tact, resourcefulness, and skill at her command to persuade the individual that there is still much in life for him; that he can carry on if he has the will to do; that he has his visual memories; that there is beauty of the world around him that he can still enjoy. If the person is in a hospital, is an out-patient, private patient, or home patient, then the medical social worker, the occupational therapist, and the public health nurse have an opportunity to exercise an equally important role.

The newly blinded person should be treated as any other patient. Doctor, nurse, and patient should have the correct mental attitude toward loss of sight—that blindness is not a handicap but an inconvenience that can be overcome; that it need not become on affliction if the mental attitude is right. After all there are few individuals who do not have a handicap of one kind or another—defective hearing, loss of a limb, or even a bad temper! He must early realize that he must adjust himself to live in the world of which he is a part and that it will not adapt itself to the individual blind man or woman, for there is no world of blind people into which he is going to be transported. Above all, he must be encouraged to continue to function as a seeing person, seeking his own friends and contacts and, where feasible, continuing in the same line of work as before loss of sight. Remember that it is not the handicap of blindness that counts, but the personality and the will-to-do behind the handicap.

The occupational therapist may be introduced early in the treatment to great advantage. This may be affected even before the patient is able to do things for himself. Both nurse and therapist together can give him the right mental point of view by telling him what he can do and what others, similarly handicapped, have done.

The man or woman for whom blindness is imminent usually knows nothing of blind persons, their possibilities or their achievements. He naturally thinks that when his vision goes all avenues are closed. Bring to his attention the stories of successful men and woman, not only of Milton, Fawcett, Senator Gore, or Dr. Babcock, but also of those of ordinary ability and intelligence who have fought their way successfully through life despite loss of sight. Even before the patient is allowed to sit up, if he is permitted to use his hands, he can be taught how to tell time by simply taking the crystal from his watch or clock; he can be taught to tie knots so he later will be able to lace his shoes; if he likes flowers give him a bulb to plant, preferably one with a sweet smelling flower which he can watch grow and whose perfume he can enjoy. Above all do not fatigue the patient; first calls should be of short duration and very friendly so that the patient will look forward to the next visit.

During this period of adjustment, extreme care must be exercised to keep in mind the character, background, and ability of the newly blinded person so that the suggestions made will be helpful and not irritate. The nurse or occupational therapist at first should not be concerned unduly with the workmanship of an article whatever it may be, but rather strive to inculcate in the newly blinded person a desire to do and the knowledge that he can do things. Do not think that a basket is the only thing the newly blinded person can make or that the learning of Braille is the first requisite to adjustment. Psychologically they may be the things that will thwart a speedy readjustment. The nurse can teach the patient to feed himself, to cut his meat, and spread his bread with butter. She can also encourage him to care for his own toilet—bathe, shave, dress—and even to smoke as he did before loss of sight. In the case of women patients, proper makeup, dressing, and style of hair are important.

As soon as the patient is able to be out of bed, teach him to move freely and independently about his room. Begin perhaps at the door and let him walk around making a circuit of the room, touching every article of furniture, doors, and windows. By so doing he is able to gain a mental picture of his room which will help him gain confidence in himself and will assist him when he goes home or into new communities. Teach him how to walk easily and inconspicuously by taking the arm of the guide —in this way he senses the step up or down, the turn to right or left, by the motion of the guide's body and it will soon be unnecessary to give verbal directions. He also will gradually

increase his sense of direction by sounds, odors, et cetera, which he will associate with locations. Teach him to keep his clothes separated in the dresser and in the clothes closet so that he may match up his clothes, ties, and socks himself.

Games such as checkers, chess, and dominoes are valuable in developing the sense of touch. Cards also may be useful in introducing Braille.[1]

Encourage the newly blinded individual to continue script writing by supplying a writing board; he should at least continue to sign his own name so that he may take care of his business affairs. The Talking Book[2] also may prove both stimulating and diverting to him.

If there is an occupational therapist on the hospital staff, she may be the one to contact the family to give its members the right attitude to take toward the newly blinded member. However, in many cases this duty will fall upon the nurse. Too often the relatives wait upon the blind member too much. This is prompted by the utmost kindness, but it should be pointed out that this mistaken kindness may often retard or thwart the individual's adjustment to his loss of sight; that every effort should be exerted to enable the newly blinded person to function as a normal member of the family group and of the community.

Ability to move about and carry on normal social activities is important, but equally so is the desire to continue employment or prepare for new work. A person's self-respect depends in considerable measure upon his ability for self-support. There are many agencies established for the aid of blind peaple and by all means use all facilities available.

[1] These games, Braille marked cards, and other appliances may be secured from the Howe Memorial Press, 549 East Fourth Street, South Boston, Massachusetts.

[2] The Talking Book may be secured through a state or local organization for the blind or the American Foundation for the Blind, 15 West 16th Street, New York City. The Talking Book is a long playing record used on a specially built machine like the old gramaphones. A large number of books have been recorded and have been deposited in designated libraries for circulation. These records are sent free through the mail as are Braille books. There are a number of current magazines in Braille. The *Reader's Digest* is not only printed in Braille but is also available on records for the Talking Book. Information about the Talking Book, the *Reader's Digest*, or other Braille literature may be secured from the American Foundation for the Blind, 15 West 16th Street, New York City.

Those newly blinded individuals capable of employment, who will fall within the range of eligibility, should be encouraged to secure a dog guide. The greatest difficulty the loss of sight imposes on the normal individual is inability to move about freely and independently. The removal of this difficulty through the medium of the dog guide brings about an immediate uplift in morale and self-confidence and self-esteem are restored. These changes are indicated in a new outlook on life; latent talents are released and are reflected in greater efficiency in work and in family and community relationships. For the unemployed, this freedom of movement widens the field of employment opportunities, the exercise involved results in improved health, and the status of the individual in the family group often changes as the blind member's economic ability is demonstrated by new employment or by increased earnings. Another effect of this independence of movement is the freedom which will be given the members of the family who no longer will have to hold themselves in readiness for guiding.

If the newly blinded person is approached and looked upon as a normal human being and given sympathetic understanding rather than maudlin sentimentality; if he is encouraged by all those with whom he comes in contact to do all that he possibly can for himself and given praise where praise is due and constructive criticism when necessary; if an effort is made to assure him that he still has his rightful place in the family and the community; and if he is shown the guide-posts which will permit him to carry on his life almost as effectively as heretofore; then those who have had the opportunity of showing the patient that he still is himself and can lead a full life in spite of blindness, have rendered a true service not only to the individual but to his family and society as well.

The name of Mary Dranga Campbell is synonymous with work for the blind as she is one of a family of seven who have been active in that field for more than half a century. Prior to her retirement in October, 1945, she was Executive Secretary of The Seeing Eye, Inc., for eleven years; and has been Executive Director of the Pennsylvania Council for the Blind; the Missouri Commission for the Blind; and reorganized the Department for the Handicapped, Brooklyn Bureau of Social Service.—Ed. Note.

Occupational Therapy and Rehabilitation in Europe

As reported by SALLY EMLEN, O.T.R.

The following excerpts were taken from letters written by Sally Emlen, graduate of the Columbia Occupational Therapy course, Class of 1946, who sailed for Europe as the first Occupational Therapist with a Rehabilitation team of six members under the auspices of the Friends Service Committee.

Miss Emlen's first letter was written in August, 1946, just after her arrival on the other side and during the period of waiting and training. She describes an interesting visit to the Hamstead School of Occupational Therapy in London and speaks of the three years course, for both men and women, the emphasis on the study of psychology, of the patients and of the student, and the work in "joinery," bookbinding, etc. Her second letter was mailed in the British Zone of Germany in October and contains the following:

"While I think it has been only two weeks since I actually mailed my last letter, it has been a lot longer than that since when it was first started and now there is lots to cover. Days are full, but don't seem rushed because you are doing so many odds and ends. It is only at the end of the day that you realize you have been quite busy. But I am only speaking for myself because my work is strictly local, not punctuated by long trips over the countryside, i. e., a five hour trip to collect furniture for a family, weekly trips to Holland and Amsterdam to collect vegetables, trips to the French Zone for mattresses, etc. Tho I may get to the American Zone—heaven knows how or where I will get the permission, but there are some medicines and x-ray film we need badly and the American Zone has it, it is *rumored.* Never believe a rumor until you have it in hand—the object of the rumor, that is!

"Our deal with Holland is very nice. Eleanor and I went one weekend to the place where their old FRS team worked after the dykes had been flooded. It was just a visit and with half an idea of getting apples if they had any to spare, for bunker children Eleanor had in her camp. The result was not only an ambulance load of apples on that trip, but a weekly gift of fruit and vegetables to German bunker children in Oberhausen. Bunkers, incidentally, are huge cement buildings which were bomb proof, the walls reinforced cement 4 to 6 feet thick, and no windows. Many families still live in these because there is nowhere else to go and they live in about the most unhealthy conditions you can imagine, name it and we have it. Bit by bit the bunkers have been closing but there are several left in the city, and in the meanwhile the people in them need help. These bunkers are a little hard to imagine until you go inside one. They are about six stories high and seem to go forever in passages and rooms. There is no fresh air, but a ventilating system of sorts, altogether like a large apartment building with one door at the end of a long cement passage for protection, and no other openings whatsoever. And they are overcrowded in addition. In Duisburg the IVSP is trying to get permission to blow windows but there is much resistance still for the people feel they will no longer have protection in the next war—which they all take for granted will be with Russia. I have seen several bunkers built under hills, the hospitals have built these and moved their entire population in during raids, operating room and all. In no case has anyone been hurt who was inside a bunker during a raid."

Speaking of a visit to the rehabilitation center at Bad Pyrmont, Miss Emlen writes, "The set-up for amputees in the town has been going since about May, run by Germans, and now with the help of BRC. There is about a 17,000 (1700?) bed hospital capacity in the town and 500 amputees, of which 400 are German and the others DP's. The artificial limb factory is small, and was on the basis of about 40 or 50 a month, now this has been raised and last month they produced 83. Each month 50 are taken by UNRA (no matter how many are produced, if only 51 are made UNRA gets 50). The limbs are made of wood and leather en-

tirely, but BRC is interested in getting a machine for making them out of light metal. (The only machine was taken to the Russian Zone.) Each leg is made specifically to order for the individual case, but the output of the factory is terrible slow so the amputees usually start with 'Hilfspotses' wooden stumps, and the transition from these takes time to learn the new feel and balance.

"The physical training is done in groups of ten or twelve so they can be supervised. Each group receives a three quarters of an hour gym period three times a week; attendance is required. In addition there are two two-hour periods a week that are voluntary. Each period is roughly divided into three sections; ¼ hour gymnastics, various calisthenics to strengthen the muscles of the body, the stump, the good leg, etc; ¼ hour of games; highjumping, ringhockey, a kind of volleyball where the ball is bounced on the floor; and highjumping was the most amazing, they reached a height of 1 meter 30 cm—over 4 feet—and this on a hard floor and no mats to land on; and ¼ hour of exercises with medicine balls, such as kicking the ball around with the stump to strengthen it.

"Beside the gym, there is massage, heat treatments, etc., and all, of course, is prescribed by the doctors. It takes on the average six weeks for them to learn to use their limbs, but each case is different. There are all sorts of exercises to develop balance, among them bicycle riding and they are hoping to get a gramophone and have dancing for them. The next step is training in occupations. They have a toy factory going now, which employs about 17 men each morning. They earn a little money as well as get a start on a profession which they may go on with later, and it also helps to pass the time while waiting for a limb. BRC is hoping to add to this with shoe-making, tailoring, carpentry and light metal work. All this caters very nicely to men who have lost legs, but they are making little if any attempt to help those without arms, the main trouble being that material is so scarce that authorities would rather allocate it for legs. Here I disagree, and the quantities of people you see without arms is pitiful.

"A request has come to BRC and UNRRA from Baltic DP's, mainly Esthonians, for another center for their people. They hope to be able to have limbs from Bad Pyrmont and then set up complete retraining right through to vocations and repatriation. The location of this is in a little village called Eldigen near Celle, which is about an hour northeast of Hannover. They have a huge schloss there, a moat around it and everything I hear, everything except heat, light, water, furniture and food at this point. It will house a doctor, nurse and training staff and 120 patients, and in addition for two months, two FRS people to help things get going. I will be one of them, if FRS London approves.

"I visited the walking school and the limb factory nearby. They are doing a beautiful piece of retraining and the patients are doing well on their new limbs. Out of a population of 175,000 in Oberhausen, 4,000 are amputees; they have three small limb factories and scarcely enough supplies to keep them running."

At Christmas time another letter arrived, reading, in part, "I have finally worked in some O. T. but it is more like the biggest organized scrounging party of the year. It is setting up a rehabilitation home for many injured Baltic displaced persons. It is rehab. from the word go, most of the patients are amputees, and when they are discharged they are supposed to have a new vocation tucked under their wing! They are an energetic bunch of people full of ideas and keep my co-worker and me constantly on the run. I'm sure I'm going to forget which day is Christmas."

Meet Our President . . . Mrs. Winifred C. Kahmann

Winifred Conrick Kahmann was born May 24 (way back when) at Westwood, Mass. Of all things she had to be one of Gemini twin girls right when her parents so badly wanted a boy. There already were three girls in the family, then another came later, to total a half dozen girls for Mr. and Mrs. William J. Conrick.

She's been the only wanderer, though, from the old New England sod, and O.T. is responsible for that. After graduating from Dedham High School and working as a stenographer for a year, she was searching around for something new and different in the way of a career. Finally she found it in the basement of the Massachusetts General Hospital where a little tiny O.T. shop was being conducted by Marjorie Blake who had received her training at Devereux Mansion under the late Dr. Herbert J. Hall. Promptly a trip to see Dr. Hall was planned but Connie was told that she was too young to think about working with patients. However, after six months she returned to convince Dr. Hall that she was now a year older.

That one year of training was a grand experience, for Dr. Hall truly inspired his students with the mission of O. T. There were only two other students in the class and all the medical lectures were held in Dr. Hall's office. It was more like private tutoring than the classes we know today. Those bi-weekly lectures and the weekly visits from Boston of Drs. Joel Goldthwaite and Loring T. Swaim comprised the theory of O. T. in the course at Devereux Mansion, at Marblehead, Mass.

When the Boston School of O. T. was started to train therapists for World War I, Dr. Hall discontinued his course at Devereux Mansion.

The first position was to open and conduct occupational therapy for out-patients at the Washington University at St. Louis, Mo. The family felt that she was going into the wild and woolly west where buffaloes roamed the prairies.

Among other things she became a member of the first curriculum committee for the then new St. Louis School of Occupational Therapy and took all of the theory with one of the early courses in that school.

Then as now, there was a scarcity of trained therapists. She had the urge to do post war work and spent one year in the Public Service Hospitals at Philadelphia and New Orleans, La.

It was then that Dr. Hall asked her to come back to Devereux Mansion to take charge of the Occupational Therapy Department, where she stayed until the death of Dr. Hall three years later.

It seemed now that she was destined to become a Middle Westerner because she chose as her next post the new James Whitcomb Riley Hospital for Children at the Indiana University Medical Center, Indianapolis, Indiana. Within the Medical Center O. T. has spread to the Robert W. Long Hospital and the Rotary Convalescent Center. In 1934 she was appointed as Director of Physical Therapy as well as Occupational Therapy. In this connection she serves in an administrative capacity for she is not a physical therapist. The treatment program in physical therapy is directed by a highly qualified physical therapy technician. Here she has been since 1924 with the exception of two years on leave of absence while serving with the Army as Chief of the Occupational Therapy in the Office of the Surgeon General in Washington, D. C.

Her years at Indiana University Medical have been full of stimulating experiences and she has taken advantage of her situation there to further her professional status through lectures at the Medical Center and courses at the Extension Division of the Indiana University at Indianapolis.

It seemed that associated professional activity has consumed her interests for she has served in numerous capacities in allied professional and welfare circles. Among these are the following:

First Chairman of the Committee on Education of the AOTA - 10 years; Board Member of the AOTA - 13 years; President and one of the founders of the Indiana O. T. Assn.; Board Member of the Marion County Society for Crippled Children and Adults; Member of the Professional Advisory Committee for the Indiana Society for Crippled Children and Adults; Member of the Marion County Chapter of the Nat'l Foundation for I. P.; Chairman of the War Service Committee of the AOTA working with the National Research Council, Washington, D. C., on the program of O. T. for the Army; Chief of the O. T. Branch, Office of the Surgeon General, Wash., D. C.; President of the AOTA - elected August, 1946.

Of course you know she married Raymond J. Kahmann of St. Louis, December 29th, 1934 and after all this they still live happily at 1924 N. Talbott, Indianapolis, Ind.

For her service during the war, Mrs. Kahmann has received a commendation for Meritorious Civilian Service. The Citation reads as follows:

"As technical advisor to the Surgeon General in all matters pertaining to Occupational Therapy and with comprehension of emergency needs and vision with respect to long range requirements Winifred C. Kahmann has participated in the organization and direction of Occupational Therapy in the Army, preserving the highest professional standing in selecting and training therapists and in establishing the therapy and training programs to hasten the recovery of individual patients—a valuable contribution to the mission of the Medical Department of the United States Army."

Meritorious Civilian Service Awards

Meritorious Civilian Service Awards have recently been conferred on Miss Wilma West, O.T.R., and Miss Mary Reilly, O.T.R., for outstanding services during the war.

Miss West, formerly in the office of the Surgeon General of the War Department, was the recipient on Nov. 22, 1946, of the Award by the War Department for her direction of occupational therapy clinical training in the Army hospitals during the war, and for her contribution in the preparation of the War Department's policy-forming manual of occupational therapy. The award was made by Col. Carl Mitchell, Commanding Officer of McCornack General Hospital, at a ceremony at the University of Southern California with President von Kleinsmid presiding.

Wilma West

Mary Reilly

Wilma West, whose home is in Rochester, N. Y., is a graduate of Mt. Holyoke College and the Boston School of Occupational Therapy. Previous to her work in the Office of the Surgeon General, she was at Walter Reed General Hospital and at the Robert Breck Brigham Hospital in Boston. She is now doing graduate work at the University of Southern California under the first Baruch grant to an O. T.

Miss Reilly, until recently O. T. Consultant, Service Command Surgeon's Office, Fourth Service Command, Atlanta, Ga., was cited for outstanding devotion to duty and superior achievement in the establishment and supervision on the O. T. program for the Fourth Service Command from December, 1944, to February, 1946.

She began her Army career as Chief O. T. at Lovell General and Convalescent Hospital, Fort Devens, Mass. Her later work in the Fourth Service Command included supervising O. T. programs in 11 general, two convalescent and six regional and station hospitals. She also rendered technical assistance in the publication of the War Department Technical Manual 8-291, the Medical Supply Catalogue 10-23 and the Apprentice Training Course of Study.

Miss Reilly, whose home is in Roslindale, Mass., is a graduate of the Boston School of Occupational Therapy. Before the war she was Director of Occupational Therapy in the Sigma Gamma Hospital School, Detroit, Mich.

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EDITORIAL

As the first *American Journal of Occupational Therapy* goes to press, its editors wish to express their admiration and thanks to the members of the profession to which they belong, and which the Journal will serve.

The first issue had a deadline which occurred between Christmas and New Year's. The contents were produced therefore by your fellow members in the very midst of holiday activities — thereby disproving a myth that O.T.'s are too busy and too individualistic to cooperate in group projects! They made this effort to bring you the February issue — and we in the office find the outcome so commendable that we look forward eagerly to the results which may be produced when we have the additional support of those members whom we could not reach until this moment.

AJOT has tremendous possibilities! There is no end to the opportunities which are offered to us through the medium of the written word of our own professional Journal. It can represent the thinking of O.T.'s from every corner — if you will contribute to it or will make constructive suggestions. It can serve you who are in remote or segregated areas by keeping you aware of new trends; it can be a medium of exchange for research findings and ideas for those who are too busy to visit other departments; it can familiarize all of us with the activities of our own and of other professions so that, observing the efforts being made to promote plans which are of interest to us individually, we can give them our active support or we can express our opinions where they will be heard. We will know where to find our rallying points! It is particularly important for each of us to know about the activities and projects of our national committees and it is for this reason that we have asked the chairmen for general information regarding their aims, purposes and functions. At the moment some of these committees are undergoing changes, but we have been promised more complete information for another issue.

This is a period during which occupational therapy should stabilize its gains and thrust itself ahead on the knowledge and momentum gathered from its war services. Not to advance

now, with the other medical profession groups, is tantamount to going backward.

This means that there is nothing more pressingly necessary to us at this moment than that we have strong coordinated leadership in our national office, and *active* cooperation of the membership-at-large. We should use every effort at our command (and this effort should hold precedence over everything else) to obtain strength and unity and coordination in our affairs, so that occupational therapy can achieve its proper place as a recognized form of medical treatment.

Leadership and membership are not of value unless they work as a cooperative team. Leadership must have an active following if it is to accomplish the larger purposes for which it is elected by the membership. In order to bring this about, there must be some mode of conveying stimulation and information to the members from the national office, and some means of presenting the thinking of the membership to the group which they have voted into executive office. This brings us to a statement of the aims of AJOT. We believe that your professional journal is the natural and feasible vehicle for this exchange of information. We expect to promote knowledge and understanding of occupational therapy — we hope also to offer those services which will aid in welding our membership into a united whole so that we may better approach those projects which must be accomplished if we are to raise our standards and advance our profession.

The Journal can specify its aims but it cannot, alone, obtain its purposes — we cannot grow individually except as we grow by the whole — but it can and does provide *you* the means to realize these purposes, for AJOT will be your mouthpiece.

The Journal has many Divisions and there must be one area, at least, which catches your particular interest and to which you will contribute. When we accepted the editorship, along with our regular jobs as active O.T.'s, we were told that our primary difficulty would be to make O.T.'s divulge their ideas and research findings into areas beyond their particular hospitals or state associations. We feel that the therapists who made the first issue possible are perhaps typical of the whole profession — we think that with a vehicle which *needs* your material for the betterment of the profession, you will provide it.

We would like to call your particular attention to the article by Dr. Hyman Brandt in this issue for it describes the start of a national project which will undoubtedly influence or directly affect the entire O.T. field. The preliminary survey and compilation of school curricula provides a basis for not only the national registration examination, but for the standardization of courses, so that all students will have equal opportunity for preparation to practice in the O.T. field. Since this survey includes also clinical training, it provides a basis for setting up minimum standards for training centers — and later, for the accreditation of occupational therapy departments.

The Student Section of the School Division, headed by the editor of The Student Bulletin, is one which we should all watch with interest, for our thinking cannot be complete without including those who are next in line to carry forward the principles and practices of our profession.

You may note that we have featured a Canadian School in this first issue. We expect to have, in time for the next issue, a regular editor who will supply us with NEWS from across our Northern border. We may be able, at the same time, to announce an editor who will keep us abreast of occupational therapy as it is practiced in England.

It is our intention to carry advertisements of only those supply houses which have been recommended by occupational therapy departments. If you place your orders with our advertisers, you not only have a good recommendation for their reliability, but you are helping the Journal.

The Journal happens to be published in New England, and we hope you do not object to having it come to you from a spot which we have been given to understand "is remote!" If you will observe our list of excellent Division Editors (who, with the Delegates and school directors, are really responsible for this issue) you will see that we have tried to counteract our location by a preponderance of editors from *other* remote spots!

In the next issue we will have a picture of the Coronado Hotel and a story concerning the 1947 Convention.

American Occupational Therapy Association, 33 West 42nd Street, New York 18

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Educational Field Secretary
Miss Sue P. Hurt, O.T.R.

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PRESIDENT'S MESSAGE

The American Occupational Therapy Association celebrates its Thirtieth Birthday during 1947. Thirty years is a good mature age with which to venture forth with our own American Journal of Occupational Therapy.

With the war past and a greatly increased membership in our association there are still not enough qualified registered therapists to meet the demand in our civilian and veteran's hospitals. The psychiatric and tuberculosis hospitals, particularly, are critically understaffed with occupational therapists.

Everyone is tremendously busy but you know that it is the busiest people who get things done. So, it is our hope that this beautiful new child—your own official professional magazine—will inspire you with the urge to help support it by your contribution to its content.

These are days packed full of opportunities and experiences which we all wish to learn about. The latest developments and the ingenious techniques in the treatment field of Occupational Therapy should be made known to everyone. You know the physicians who are using occupational therapy service in this present era of medical rehabilitation. It is not new but has taken on new meaning with the impetus of the war experiences wherein great medical minds were concentrated on the purpose of restoring health and a normal function of life out of the physical destruction and the social chaos of war.

Occupational therapy service in civilian hospitals and community agencies has suffered during these years from lack of personnel and insufficient funds to meet the rising salary scale in government and federal agencies.

Nevertheless it now remains our common purpose to maintain the best possible opportunities for the physical, social and economic stabilization of the sick and injured whether veterans of the war or veterans of the hazards of disease and industrial injury. The glamour of battle is over when we realize its distress; and the underprivileged, the sick and disabled, physically and mentally, are always with us.

There's a great deal for occupational therapists to do and the opportunities are limitless. We are not too well prepared but we are healthy and vigorous. Let us take our task in hand, be guided by our medical advisors who have come to know us better, and accept our responsibilities toward the planning for the future in the specific treatment phases of occupational therapy.

We must continue to work in the direction of sound reasoning for the things we do. Our techniques have proven helpful, physically and psychologically, in conditions of acute illness and in convalescence, but we need further to carry on research in occupational therapy in order to clearly demonstrate treatment procedures. Ways and means may well be made available if we prepare ourselves to meet this need.

There are among us many therapists with interests and abilities of which we know little. You are urged to come forth with your ideas. Perhaps they are new, perhaps you can be of help, and quite possibly the association can help you to develop them. We must know you better. Any registered therapist has attained that status because of her educational and professional training and ability. The field of occupational therapy needs you each and everyone and your association wants to know you intimately. More committee workers are needed, and now you have this fine new magazine to foster and support, THE AMERICAN JOURNAL OF OCCUPATIONAL THERAPY, with one of our ablest OT's as editor. Aren't you proud!

There are other things to be proud of too! You will find among these pages a fund of information concerning the business of the American Occupational Therapy Association. All of the new Committee members, and the reports of the various committee activities since their appointment in October, at which time the first Executive Committee meeting, since the Chicago Conference, was held at the national office.

Perhaps the most significant and important activity of the association to you as individuals, at present, is that of the Educational Field Secretary. Dr. Hyman Brandt, a test expert,

has been appointed as consultant to our efficient Sue Hurt in the Educational Field Office. Working with them the Registration Examination Committee promises to produce an educationally and professionally sound registration examination.

This entails a tremendous amount of research into the content of the OT courses in the accredited schools and the specific content of the clinical training in hospitals and other agencies in which occupational therapy students receive their clinical practice. Many therapists who are specialists in the various disability fields have worked arduously under Miss Hurt and Dr. Brandt's guidance to compile the necessary information. For two weeks over the Christmas holidays, on leave of absence from their positions, they labored in the national office to provide the necessary data. This is real sacrifice and a great contribution toward the construction of an adequate registration examination.

Through your state associations you have learned of the proposed public relations campaign. Many of the state groups have made valuable suggestions for which the association is most grateful.

Part of this program has already been accomplished. We hope you will be pleased with the booklet on Occupational Therapy which may be widely distributed and which may be obtained in quantity on request from the national office. It is hoped that this literature will be of valuable service to you in your public relations activities in your communities. There has also been newspaper publicity and magazine articles arranged by the news service. However, due to the pressure of the more important professional issues of our association the Public Relations Committee have deemed it advisable to terminate the contract with the Phoenix News Bureau. This action renders this new magazine all the more important. It is our best publicity vehicle. You will receive it as a member but we know you will wish to inform your professional colleagues, your hospitals, the libraries of your institution or agency about it too.

The next Board meeting of the association will be held early in March at Philadelphia. It is expected that the progress of the committees will be reported at that time. All this will be news in the next issue of this journal. Do let us have your news also.

Now back again to that Thirtieth Birthday. You have already been informed that the next annual meeting will be held in California. So it is! The time—October 31st to November 7th (the best we could do as to date in any hotel in California). The place—that gorgeous Hotel del Coronado, "Across the Bay" from San Diego—just 200 miles from Los Angeles. There will be beautiful and adequate meeting rooms for the conference and the committee meetings. And, of all things, swimming, tennis, sailing, and "beaching." The food I'm told is "out of this world." Best of all—it is very reasonable. So, do plan a late vacation and help to make our Thirtieth (grown up) Anniversary a real success. Any and all suggestions for the program and the institutes will be gratefully received.

In anticipation of your loyal support,

WINIFRED C. KAHMANN, O.T.R.
President

COMMITTEE REPORTS

STANDING COMMITTEES

REGISTRATION COMMITTEE

Alice Letchworth, O.T.R., Chairman

Registration in the A.O.T.A. often becomes confused with membership in the Association. Let us explain that by membership in the Association you are joining with a group interested in the promotion of the profession, in the study and advance of all Occupational Therapy.

The Directory, published each year by the Association, is for the benefit of those therapists who are fully qualified by their credentials to practice Occupational Therapy and to use the letters O.T.R. after their names, signifying that they have taken the registration examination and have joined the Register.

Registration was created in 1930, "for the protection of hospitals and institutions from unqualified persons posing as Occupational Therapists."

The duties of the Registration Committee are to pass on the qualifications of all applicants prior to taking the Registration Examination; and through recommendations to the Board, the changes or additions necessary in the "Plan," for keeping standards at their highest; and the publishing of a Directory or Supplement each year which includes the names of all Registered Therapists and other pertinent material that will provide a Handbook which will be of service to those in the field.

As a Committee we wish to serve our members, the

profession, and those who use Occupational Therapy in any of its branches. We welcome your advice and recommendations, for by these we will better serve your needs.

SUB-COMMITTEE ON EXAMINATION

Sue P. Hurt, O.T.R., Chairman

The purpose of this sub-committee is to develop a sound procedure for evaluating the fitness of the graduate occupational therapist for professional registration. The present Educational Research Program had its inception in the recommendation of this Committee.

EDUCATION COMMITTEE

The Education Committee which had grown to unwieldy size because of the great increase in the number of schools was reorganized last year with two sub-committees, the Sub-Committee on Schools and Curriculum, the Sub-Committee on Clinical Training, and a Steering Committee.

STEERING COMMITTEE

Helen S. Willard, O.T.R., Henrietta McNary, O.T.R., Co-Chairmen

Membership. As first organized the membership consisted of the directors of ten schools selected from the East Coast, Middle-West and West Coast, each school to be represented for two years. In order to initiate a stagger plan, one-half of the beginning ten schools were appointed to serve three years at the outset. The ten schools selected were St. Louis, Philadelphia, Milwaukee, Boston, Western Michigan, Illinois, Southern California, Mills Richmond and Columbia.

This organization is now being modified so that the Steering Committee will eventually be made up of equal representation from the Sub-Committee on Schools and Curriculum and the Sub-Committee on Clinical Training. The Chairman of each of these committees is a member of the Steering Committee. The Educational Field Secretary and the Chairman of the Registration Committee are members ex-officio of the Steering Committee.

Function. This committee serves as a body for policy making to act on recommendations received from the sub-committees and to co-ordinate the activities in the educational field. It will make recommendations to the American Medical Association in regard to revision of essentials for accredited schools and in general will serve as the clearing house for educational matters which are to be presented to the Board for action.

Meetings. This committee will meet regularly at the time of the Board meetings and at such other times as may seem necessary.

SUB-COMMITTEE ON SCHOOLS AND CURRICULUM

Beatrice Wade, O.T.R., Chairman

Function. This committee acts as a forum for the discussion of problems relative to curriculum building and course content. It is interested in the consideration of teaching methods, student selection, or the discussion of any subject which will tend to raise the educational standards of the profession.

Its special project for the next three years is the development of a "Curriculum Guide," which should aid materially in determining the specific didactic and curriculum instruction and experience essential to the program of study for service in this field. The chairman of the Sub-Committee on Schools and Curriculum has established a committee for the curriculum guide, chairman of which is Miss Henrietta McNary. Plans have been made for the immediate initiation of a preliminary study which is essential to the eventual completion of the guide.

This project will benefit greatly from the current study now being made by the participants of the Educational Research Program. Though active interest in problems relative to schools and curricula will be sustained, the main purpose of the sub-committee for the next three years is the development of this curriculum guide.

Relation of the Sub-Committee to the Steering Committee. This sub-committee is a vehicle of discussion, not of decision. The membership makes recommendations to the Steering Committee of the Committee on Education and in turn will have projects for study released to it by the parent committee. An example of this relationship is as follows: The sub-committee recommends to the Steering Committee that there be initiated a project which would lead to the eventual formation of a curriculum guide. This recommendation was approved and responsibility for the project was assigned to the sub-committee.

Membership. In accordance with the reorganization plans effective April, 1946, the membership of this committee now consists of the directors of accredited courses.

The membership at the present time numbers eighteen; additional members will be added as the more recently established courses are approved. The directors of courses, which have been designed to meet requirements, but which have not yet been accredited are welcome, in fact, urged to attend meetings of this committee and to call on it for any assistance which its membership is capable of rendering.

Meetings. Plans are being made to hold extensive meetings of this committee in conjunction with the annual and semi-annual meetings of the Board of Management. The first assembly since reorganization was in Chicago, August, 1946; the next will be held in Philadelphia, March, 1947.

SUB-COMMITTEE ON CLINICAL TRAINING

Margaret Gleave, O.T.R., Chairman

Function. This committee considers all matters pertaining to the clinical training of students with special emphasis upon the preparation of a clinical training manual which will serve as a guide for teaching hospitals. Recommendations will be made to the Steering Committee and in turn projects for study will be released to it by the latter committee.

Membership. Members are selected from among the clinical training directors of each accredited school. A balance of representatives of each specialty will be maintained.

The Chairman of the Sub-Committee on Schools and Curriculum will serve as a member of this committee.

Meetings. Meetings will be held at the time of the annual meeting and, if necessary, at the time of the mid-year Board meeting.

SCIENTIFIC STUDY AND RESEARCH COMMITTEE

Carlotta Welles, O.T.R., Chairman

This section is included in your Journal because of popular demand. Study and research will be freely discussed because you have asked for it. The Scientific Study and Research Committee has planned a threefold program which is outlined here in the hope that many of you will want to comment and contribute.

It will be helpful to each occupational therapist only if she will take time and give a little thought to becoming what might be called "research minded." The application of critical thinking to one's own work is often the means of saving time or developing a new technique which has definite value to others in the field. Critical thinking will also determine what would be worthwhile study both for us as individuals and on a national scale. There is not one of us who does not want to study, but it is suggested that some things are best studied on an individual basis while others should be done as a group project for presentation to the field. This is because of the two variable factors in each treatment situation, the therapist and the patient. Each affects the other in ways which cannot be measured or definitely evaluated. Each therapist has developed treatment procedures which bring about the desired result but which may or may not be used effectively by another. Therefore, it is urged that each of us become "research minded," and look first at our own program, bearing the following in mind: What am I doing which could be helpful to others in the field; what research or study projects, which if done by a specific group, would definitely help my department; and third, what do I need most to study?

The Second Part of the program involves the development of specific research projects as mentioned above. Occupational Therapy Projects for Men Patients and Occupational Therapy for Cardiac Patients have recently been completed and should be published soon. There has been a great demand for more research in the psychiatric field and the sub-committee on neuropsychiatry is giving this its full attention.

The sub-committee on General Occupational Therapy and Physical Function would like your suggestions. It should be mentioned that research in the field of Poliomyelitis is being carried on at Warm Springs under the guidance of a Special Committee.

It has been suggested by a professor at Columbia University that our basic source material covering occupational therapy treatment procedures is very limited. He also suggested that it would be desirable to prepare a number of case studies which describe in detail the application of treatment procedures to patients with specific diagnoses. From an adequate number of such case studies valid generalizations could be made and the case studies themselves would prove interesting research material. It should not be too arduous a task for each occupational therapy department to produce one or more very significant case studies. The preparation of one might be a worthwhile project for a student. As these are assembled they will be placed in folders or handbooks covering the several fields.

The final portion of the threefold program included advanced study for the graduate therapist. Many registered occupational therapists have expressed a desire to undertake further study, but facilities for developing this have been very limited and most of our attention has been given to the training of the undergraduate. There are two ways in which advanced study might be worked out. One would involve appropriate university courses carrying graduate credit. The second would be a rotation affiliation plan among several participating institutions whereby a therapist would retain her salary from her own hospital while affiliating at several others. Each department would have the benefit of several therapists from other institutions for a limited period and the personnel level in each department would be maintained at all times. This committee will give considerable attention to developing such a plan.

In conclusion it is emphasized again that this is *your* program. You are urged to "think on these things" and write to this Division Editor your questions, comments and suggestions. You will soon be asked to help in the preparation of case studies. Our goal is to develop a program of scientific study and research which will prove helpful to each occupational therapist.

LEGISLATIVE COMMITTEE

H. Elizabeth Messick, O.T.R., Chairman

Following a request for joint action of the legislative committees of the Ameriean Occupational Therapy Association and the American Physical Therapy Association, a meeting was held in Washington, D. C., on 12 December, 1946. Representatives of the occupational therapy group were Sue Hurt, Ruth Brunyat, Rhoda D. Lester, and H. Elizabeth Messick. Physical therapists present were Miss Mildred Elson, Executive Secretary of the American Physical Therapy Association, Miss Evelyn Byrd, President of the Maryland Physical Therapy Association, and Mrs. Florence Kendall, Chairman, Executive Committee, Maryland Chapter, Physical Therapy Association. This meeting was called for the purpose of discussing how the two groups might best work together for the mutual advantage of both on legislative matters. It was determined that the most serious problems facing these two professional groups are: (1) Untrained or improperly trained personnel attempting to practice occupational therapy and physical therapy and (2) The lack of qualification standards for both occupational therapists and physical therapists under state and federal Civil Service.

It is hoped that the Legislative Committee will be able to assist state and regional associations in any Civil Service or legislative problem pertaining to occupational therapy which may arise in their area. The President of the state and regional associations will be contacted concerning any pending legislation or existing problem in which the Legislative Committee may be in a position to offer assistance.

It is of utmost importance that qualifications for occupational therapists be properly outlined in any Civil Service announcement.

Sample job sheets for occupational therapist positions in the professional series have been prepared by the Legislative Committee and are available upon request to the Chairman of the Legislative Committee.

PERMANENT CONVENTION COMMITTEE

Mrs. Lucie Spence Murphy, O.T.R., Chairman

At the National Convention held in Chicago last summer, the Board of the A.O.T.A. authorized a new committee, namely, the Permanent Convention Committee.

The purpose of this committee will be to choose the locality for conventions and to help establish policies, trends, and fields of study for the next convention. Its work will be mainly of an advisory nature since the actual planning of the convention will still be the responsibility of the local group, however, the national committee will carry ideas and experiences gained from previous conventions to the new group and will help them in organization. Because the members will be from all parts of the country, they will be able to bring to the local committee a cross-section of interests, and will provide a larger field from which to obtain suggestions for speakers who will make valuable contributions to the convention.

It is the aim of the national committee to plan convention locations two years in advance so the American Occupational Therapy Association will have a better choice of suitable hotels at the time most desired. The local group will not have to worry about finding adequate space but can devote the year to the organization and development of an interesting convention. They will be able to obtain much help by observing the mechanics of the previous convention before beginning their own.

The 1947 Convention will be held from November 2 to November 7th at the Hotel del Coronado, across the bay from San Diego, California. Since California has two state associations, the local committee will be composed of members from each group. Miss Marian Davis, O.T.R., Director of Occupational Therapy at the Children's Hospital and Convalescent Home in Los Angeles, and Miss Arlene Van Derhoef, O.T.R., Director of Occupational Therapy at Mills College in Oakland, have been named Local General Co-Chairmen.

The program is still tentative but promises to provide a very interesting series of meetings for everyone, so let us all plan to attend the first National Convention of the American Occupational Therapy Association to be held on the West Coast!

NOMINATIONS COMMITTEE

Chairman not named

PUBLIC RELATIONS COMMITTEE

Holland Hudson, Chairman

The purposes of this committee are to correlate and coordinate the informational material which emanates from the national office; to promote good will toward, and understanding of, occupational therapy; and to cooperate with, or to activate, those programs which will advance occupational therapy or other allied medical professions. A peace-time recruiting circular and appropriate covering letter have been the most recent concern of this committee.

SUB-COMMITTEE ON NEWS LETTER AND DIRECTORY

Edith Brokaw, O.T.R., Chairman

The aim of this committee is to keep the membership aware of A.O.T.A. activities by direct communications from the national office. Heretofore it has been published only upon occasion, but it will now be published in the months which alternate with those of The American Journal of Occupational Therapy.

The Yearbook Directory cannot be kept up-to-date without the cooperation of the membership. It is the national files which provide your address, or your change of address, to the Journal and to others who inquire about your location.

SUB-COMMITTEE ON REPRINTS AND EXHIBITS

Chairman not named

SUB-COMMITTEE ON THE AMERICAN JOURNAL OF OCCUPATIONAL THERAPY

Charlotte D. Bone, Chairman

Special Committees

RESEARCH COMMITTEE ON POLIOMYELITIS

Sue P. Hurt, O.T.R., Chairman

The function of this committee is to promote research in the sound use of occupational therapy throughout the entire program of rehabilitation of the poliomyelitis patient, and to make the results of this research available throughout the country.

RULES AND PROCEDURES COMMITTEE

Mrs. John A. Greene, Chairman

Rapid growth of the American Occupational Therapy Association has resulted in some committees becoming too large and unwieldy so that many problems of duplication are being presented. This committee has been requested to prepare a manual correlating the procedures of the various committees of the Association.

DELEGATES DIVISION

Officers of the House of Delegates 1946-1947

Speaker
Clare S. Spackman, O.T.R., Director

Vice Speaker
Miss Bertha J. Piper, O.T.R.

Secretary
Miss Edna-Ellen Bell, O.T.R.

ILLINOIS

The I. O. T. A. holds nine or ten meetings each year from September thru June. The

programs are varied, but usually of an educational nature—whether directly occupational therapy or not. During the past year we have had unusual speakers brought to us by the efficient program committee.

Dr. Harold Storms, Medical Director of the Workmen's Compensation Clinic of Toronto, presented the general plan of the Workmen's Compensation Clinic before a large group of occupational and physical therapists. He was followed by one of his therapists, Miss Margaret Winch, who spoke on the "Correlation of Occupational and Physical Therapy in the Clinic." The later speech was illustrated with some very unusual slides portraying the actual treatments given in the clinic.

In line with the interest of therapists in other organizations Mrs. Stella Ford Walker, President of Women's Share in Public Service, gave the group an interesting background for the development of the organization and urged the members present to participate in the program and in the aims of the nation-wide movement. The I. O. T. A. is a member of the council of Social Agencies, Women's Share in Public Service and similar agencies and its role in public welfare is growing increasingly important. We feel there are many outstanding projects which merit our attention in these groups and it is fitting that we become aware of them.

Miss Isabel March, an exchange student at the Workmen's Compensation Board Clinic at Toronto, relayed to the members the work of the clinic from a student visitor's standpoint and presented a comparison with some of the clinics in this area.

Mr. Alexander Ropchan, Executive Secretary of the Health Division of the Council of Social Agencies, presented the second talk of the series planned to acquaint the membership of other groups. He spoke on the subject of "Social Service, Its Functions and Its Relation to Occupational Therapy."

* * *

The membership journeyed one evening to the Institute of Design in Chicago for a personally conducted tour and lecture by one of the instructors. He spoke on the purposes and functions of the Institute. Many new ideas of freedom in design and procedures are probably incorporated in many an O. T. department program as a result of this meeting.

* * *

After the business of the annual meeting new members were welcomed to the association and a general get-acquainted session followed. The group adjourned to enjoy summer vacations, to meet and get acquainted again in the first meeting of the fall season.

* * *

Miss Ruth Colman, Instructor in Medical Illustration, of the College of Medicine of the University of Illinois gave an illustrated lecture regarding the problems, possibilities and scope of the field of medical illustration. This was the first of a series of allied groups in the medical family which will be presented to the group during the year 1946-47.

Dr. Herbert Koepp-Baker, Director of Speech and Hearing Rehabilitation at the University of Illinois, contributed to our knowledge regarding the possibilities of occupational therapy in this field and gave us much about rehabilitation of the war injured in his particular interest.

* * *

The Illinois Occupational Therapy Association had charge of the program for the first meeting of the Occupational Therapy Section of the Tri-State Hospital Assembly held since the war. A unique program was planned on one day for the students of the five schools in the area. The students also held a get-together luncheon at the Illinois Union of the University of Illinois and voted to make this feature an annual affair.

* * *

Of course you know—we planned and planned and planned and presented the American Occupational Therapy Association convention in Chicago. We thoroughly enjoyed doing it and liked having you all with us.

* * *

The Illinois Federation of Women's Clubs established in 1944, through state-wide contribution, an Occupational Therapy Scholarship Fund. The responsibility of the scholarships lies in the hands of the special undergraduate Scholarship Committee of the University of Illinois.

Awards are made for one year and may be renewed, provided the student maintains a su-

perior scholarship record (B— or higher) and still requires financial assistance. Candidates recommended through the Federation receive first consideration, all other factors being equal. To date approximately $10,000 has been put into this special scholarship fund and fifteen students have been fortunate to have had the help and interest of this state organization.

* * *

Occupational Therapy in the Chicago area has been growing rapidly in the last six months, four new departments have been established under registered therapists.

The Haven School—Crippled Children's Room, Evanston
The Illinois Hospital School
Cook County Children's Hospital

Michael Reese Hospital is reorganizing under Physical Medicine and is setting up service for functional cases and expanding to take care of the pre-school Cerebral Palsy Unit.

* * *

The National Society for Crippled Children and Adults, Inc. held their 25th Silver Anniversary Convention in Chicago, December, 1946. The program presented much as a challenge of the future and how the group is organizing to meet this challenge. Prominent authorities on rehabilitation spoke on "Opportunities for Rehabilitation," "Comments on the Operation of a Rehabilitation Program in the City Area in State-wide Aspect," and "Place of Physical Medicine in Rehabilitation." The last day was devoted entirely to cerebral palsy,—treatment, pattern movements, adjustment, educational needs, and advances in drug therapy.

All who attended profited by listening to the outstanding speakers. It was encouraging to see a large number of therapists from all over the country. We suggest that you watch the *Crippled Child* magazine for written reports of this meeting.

The Chicago Central Service for the Chronically ill held a one-day institute for all persons interested in what Chicago is doing for this group. Dr. A. C. Ivy, Vice President of the University of Illinois in charge of the Chicago Colleges, pointed out the terrific need for establishment of special research centers for study of the chronic conditions, from the humanitarian as well as the economic aspect. In 1937 there were 23,000,000 with chronic disorders in this country. The conditions heading the list were rheumatism, heart conditions, high blood pressure, arteriosclerosis, hay fever and asthma, nervous and mental diseases. Early recognition, prevention, rehabilitation, and the care of this group were all parts of the well-planned program. *Fortune Magazine,* December, 1946 is recommended for reading, "Care and Homes for the Aged."

* * *

We welcome to Chicago, Miss Mary McDonough, Chief Therapist of the Medical Rehabilitation Section of Area 7, of the Veterans Administration. Miss McDonough recently planned and presented a very complete program for a medical rehabilitation conference which included all divisions of the service which are interested or involved in medical rehabilitation. Many physicians and surgeons on the Veterans Administration were present to give valuable information and assistance to those working in this field.

* * *

Officers of the I. O. T. A. include:

President, Miss Ella V. Fay, Cook County Hospital, Harrison St., Chicago.

Vice President, Miss Angeline Howard, University of Illinois, 1953 W. Polk Street, Chicago 12.

Secretary, Mrs. Emilie Staisey, Goodwill Industries, 1500 W. Munroe, Chicago 7.

Treasurer, Miss Ruth Russell, Veterans Rehabilitation Center, 2949 W. Washington, Chicago.

Delegate, Miss Isabel March, University of Illinois, 1853 W. Polk St., Chicago 12.

CONNECTICUT

The fall meeting was held in September, at the Y. W. C. A. in New Haven, beginning with a supper hour and combining business with pleasure. The delegate presented a resumé of the Chicago convention. A part of the evening was spent in revising the constitution in preparation for the scrutiny by the Secretary of the House of Delegates, who was instructed at the meeting in Chicago to review all state constitutions during the coming year. The delegate asked for an expression of opinion regarding

the A. O. T. A. moving its headquarters to a location farther west—one of the questions which came up for discussion at the Chicago meeting. The general attitude among the Connecticut members seemed to be that the national headquarters should be in the area where the largest number of the membership resides and where all the membership can be served most efficiently, which would not necessarily be in the geographical center.

* * *

Occupational therapy departments in Connecticut state institutions were the recipients of thousands of Christmas gifts presented by clubs, church groups, civic groups, young people's groups, and interested individuals throughout the various counties of the state during December, all donated for the benefit of patients in state hospitals. A publicity campaign promoted by the Connecticut Society for Mental Hygiene has encouraged wider interest in the care of patients in these hospitals.

* * *

Encouraging improvements in state employees' salaries have been made in the past year, and there is hope that a therapist here and there will turn to the Nutmeg State as she steps down from the munificent salary status of her army career. Gross salaries at present are: Occupational Therapist $1800-$2400; Head Occupational Therapist $2220-$2700; Chief Occupational Therapist $2640-$3120. State exams for head therapists will be given sometime in the next few months.

* * *

President, Miss Marion Maurer, OTR, Community Workshop, 136 Chapel Street, New Haven.

Vice-President, Miss Julie F. Constable, OTR, Community Workshop, 136 Chapel Street, New Haven.

Secretary-Treasurer, Miss Eleanor Kille, OTR, Southbury Training School, Southbury.

Delegate, Miss Bertha J. Piper, OTR, Fairfield State Hospital, Newtown.

VIRGINIA

The November meeting of the V. O. T. A. was a dinner meeting. Guests were Dr. A. Ray Dawson, Dr. A. S. Hurt, and Dr. Bernard Packer, all members of the Advisory group who will help us in interpreting occupational therapy to the medical profession. Dr. Dawson, as Regional Director of Rehabilitation, Branch 4 V. C. A., represents the Veterans Facilities, Dr. Hurt represents the branch of pediatrics, and Dr. Packer the field of orthopedics.

In December the Association was invited to attend a dinner meeting at the William Byrd Hotel in Richmond, at which Dr. Winfred Overholser, Superintendent of St. Elizabeth's Hospital in Washington, was the speaker.

We were happy to have a delegate from the Durham, North Carolina Chamber of Commerce, headed by Dr. Lenox Baker of Duke University, visit Richmond in December. They visited the Medical College of Virginia, The Curative Workshop, the State Rehabilitation Office and McGuire Veterans Hospital.

The Vicissitudes are great in keeping an Association going in an area where occupational therapists are still such rare birds that they can get the whole membership into the Green Room at Ewarts Cafeteria for dinner meetings without rubbing off any feathers! We therefore had to pass emergency measures to legalize our existence. Early in the fall we called a special business meeting of the Association, and in order to have more than four voting members, passed an emergency measure (limited in time), making all who had applied for registration eligible to vote. This raised our voting population to seventeen.

Officers of the Association are:

President, Dr. Joseph Barrett, Commissioner of Mental Hygiene,Commonwealth of Virginia.

Executive Vice President, Miss Helen Freas, O. T. R., Acting Director of Occupational Therapy at Richmond Professional Institute.

Secretary, Miss Kathleen Kessler, O. T. R., Director of Occupational Therapy, General V. A. Kecoughton, Virginia.

Treasurer, Miss Hilda Steinberg, O. T. R., Medical College of Virginia.

Delegate, Miss Mary Junkin, O. T. R. Director of Curative Workshop of Richmond.

We feel very fortunate in having Dr. Barrett for our president. He served at Taunton State Hospital when Dr. Overholser was Commissioner of Mental Hygiene in Massachusetts, and was the Commissioner of Mental Hygiene for the State of Michigan before he came to Virginia to serve in the same capacity.

MARY JUNKIN

SPECIAL GROUPS

Occupational Therapy — and the Navy Nurse

By Capt. G. B. Tayloe (MC), USN

For the first time in the history of the Navy, members of its Nurse Corps are being trained in the field of Occupational Therapy. The decision to offer this training was reached after long and careful consideration by the Bureau of Medicine and Surgery, and it is believed that the needs of the Navy's long term rehabilitation program will, in this manner, be steadily and adequately met.

Among the factors affecting the Bureau's decision was the one of permanence. The Nurse Corps is as yet the only group of women who are by Act of Congress a regular part of the Navy, and in building a rehabilitation program that fact had to be considered. In addition, the medical men charged with responsibility for the program had often heard expressed a preference for the nurse's approach to a patient in other specialized fields related to nursing. They were therefore in favor, for the Navy's special needs, of trying the nurse in the field of occupational therapy.

If Congress should decide that the Waves are to be a permanent corps in the Navy, it will still be possible to use to great advantage the occupational therapist members of that group. There is no doubt but what the Nurse and the Wave should supplement each other very well and that there will be plenty of work for both, considering also the factors of normal attrition and illness in any groups.

Two of the outstanding as well as the oldest schools in the country were chosen for training the nurses—the Boston School of Occupational Therapy and the Philadelphia School of Occupational Therapy — and in September, 1946, good-sized groups began the regular eighteen-month Advanced Standing Course in each School. A great many applications for the study had been received by the Nurse Corps Office, and from among these applications selections were made on the basis of the students' complete records in service and prior thereto, educational background and experience. All of the nurses were eager for the study.

Upon completion of their courses, the nurse students will be assigned in their new specialty, and it is planned that they will be kept in it. The only time when they might be used in their nursing capacity instead, would be during an emergency, when, if their services as nurses rather than as occupational therapists were necessary for a short period, they might be so assigned.

The experiment has now been launched, and we have every reason to believe that it will prove worth while. The nurses are studying enthusiastically, and, needless to say, the Navy is looking forward to the time when it can use them as full-fledged occupational therapists.

NAVY

No definite action has been taken by Congress to clarify the status of WAVES in the Navy. In the meantime, those who were accepted for retention until 1 July, 1947, have been asked to submit requests for retention until that date in 1948. There will be no count on the O.T.'s who will do this until sometime in April of this year.

Civil Service appointments are helping to supplement the WAVES and although the appointments are slow in being effected, they are aiding a great deal in swelling the ranks.

U. S. PUBLIC HEALTH

The "Physical Medicine and Rehabilitation Program" in the Marine Hospitals of the U. S. Public Health Service is the responsibility of the Director of this section in the Hospital Division.

There are 24 Marine Hospitals in the country with a bed capacity of about 6800. Of these, the hospital at Fort Stanton, New Mexico, is for tuberculosis patients and the hospital at Carville, Louisiana, is the Leprosarium. The Marine Hospital at Staten Island has a Tuberculosis Annex at Neponsit, Rockaway Beach, Long Island.

The Mental Hygiene Division maintains two Public Health Service hospitals. The one at Fort Worth, Texas, is for mental patients and at Lexington, Kentucky, both drug addicts and mental cases are cared for. These two hospitals have a total bed capacity of about 2450.

Occupational Therapy, of course, is an essential part in any sound rehabilitation program and must work in close liaison with physical

therapy. Social Service similarly is an indispensable member of a good "Rehabilitation Team." Prevocational training for those patients who must be vocationally rehabilitated is also one of the important activities of the Occupational Therapy department.

The United States Marine Hospitals are of the general type with the two exceptions as noted above and about 97 per cent of the patients are male. Out-patient clinics at each hospital add to the total number of patients to receive therapy both occupational and physical.

It is somewhat difficult to present a glowing picture of the upward surge and accomplishments in Occupational Therapy in the United States Marine Hospitals when it is as yet but an infant—even though it is a healthy one and gives great promise. Plans are going forward to increase the number of occupational therapists as conditions will permit for we are fully aware of their importance in rehabilitation which cannot be accomplished without them.

Functional Occupational Therapy is coming into its own rapidly and its place in the armamentarium of therapy is firmly established—not as a luxury but as an essential adjunct to the means of speeding recovery. To maintain this place it is incumbent on the profession to see to it that the highest quality of therapy is maintained.

VA HOSPITALS

The occupational therapy program in the Veteran's Administration hospital is slowly moving into a position from where it can show true progress. There were on duty, as of December 15, in our 123 hospitals—two of which do not have active departments—437 occupational therapists of staff or supervisory level; 376 of these therapists are graduates of recognized schools. It is also interesting to note that 269 have transferred from the Army as Army hospitals have closed. Below the supervisory level we have 203 assistants and 138 attendants, these latter groups being on the most part in our large neuropsychiatric hospitals.

There are three general types of hospitals in the Veteran's Administration. The ratio of therapists to patients in each type of hospital is as follows: one to 100 patients in general medical and surgical; one to 100 patients exclusive of attendants in the neuropsychiatric hospitals; and one to 50 patients in the tuberculosis hospitals. Many of our general medical and surgical hospitals have separate units for tubercular and neuropsychiatric patients, and the ratio is planned accordingly. Special allotment of therapists is made for programs where the need for more individual attention by the therapists is considered desirable. Such a program is the one with the spinal-cord injury cases.

The scope of occupational therapy in the VA is great as there are patients in all categories of diagnoses. There are chronic and acutely-ill patients; there are those who need only physical rehabilitation; others needing mental or social, and some needing all three. Anyone with a specialized interest in rehabilitation, could, without a doubt, find a spot where she might conduct research in that field.

There is still need of many therapists. Vacancies are reported in our southern and southwestern States. In December there were 30 in one area and 20 in another. Especially great is the need in neuropsychiatric and tuberculosis hospitals. The therapist we need is the one who will go into our hospitals in a spirit of adventure and eagerness to serve; who will work with willingness with what she finds, and work diligently until she has achieved that which we are all aiming toward—a good, efficient, occupational therapy department—one that proves our premise that we are a component part of physical medicine, an adjunct to medicine, and an integral part of medical rehabilitation.

One question that has been asked often is: When accepting a position under Civil Service are we tied to the job? A position in Civil Service does not mean that you cannot leave the Service at any time you wish; but just as in any job, it is customary to give adequate notice of intention to resign.

O.T.'S OF WORLD WAR II

The Occupational Therapy convention held in Chicago August, 1946, gave the Occupational Therapists of World War II a chance to get together and organize to carry on the spirit and growth of occupational therapy shown in World War II.

About fifty of the occupational therapists

who served in Army and Navy hospitals first exchanged greetings and experiences of where they had served and what they were doing to "adjust" to after-war occupational therapy. It was generally felt by this group that by organizing, working, and meeting as a group they could be effective in maintaining and aiding in the advancement of the profession both in civilian and military hospitals.

Groundwork for the organization was started at this meeting and by now organization is well under way with the first News Letter having been published in October and a constitution ready for ratification. There will be a national organization with local group activities. One dollar dues were voted upon until a definite ruling can be made on the amount. This will be used to cover the cost of the News Letter and go toward the projects that will be fostered.

Projects which will contribute to the field at large have been selected with a fairly long range view. A handbook on adapted equipment which will be composed of illustrations of equipment will be followed by a handbook on operating procedure for functional treatment, correlating with the handbook on equipment. Such a set of books on psychiatric equipment and treatment is likewise under consideration. The experiences of this group have been rich, and if these experiences are brought together a wealth of material would be made available not only to the Army and Navy occupational therapists but to the profession at large. Key people with experience in special fields will be responsible for gathering and compiling material from the field. Scholarships in craft study and exchange scholarships in civilian and service hospitals are other projects to be considered.

A News Letter going out to the membership quarterly will adopt a plan to keep the World War II Occupational Therapists in "the know" about her fellow occupational therapists who served with her, the advancement of medical science and studies in Army and Navy hospitals, and the progress and establishment of post-war occupational therapy departments in Army and Navy hospitals.

The membership of the organization will be open to registered occupational therapists who served in either Army or Navy hospitals in the United States or Canada in World War II. Officers elected at the first meeting to serve until the next annual meeting, which will be held at the next annual meeting of the American Occupational Therapy Association are:

Miss Susan Barnes, O.T.R., President
Miss Gertrude Murray, O.T.R., Vice-President and Corresponding Secretary
Miss Harriet Jones, O.T.R., Treasurer and Recording Secretary

Standing committees are:

News Letter, Miss Erna Rozmarynowski, O.T.R., Chairman
Constitution, Miss Katharine Rand, O.T.R., Chairman
Planning, Miss Wilma West, O.T.R., Chairman

ARMY

War Department Circular No. 349 issued on 28 November 1946 directs that a Physical Medicine Service be established as a major service in all Army general hospitals and in station hospitals of 750 or more beds.

A qualified medical officer will be designated Chief of the Physical Medicine Service. Physical Medicine in Army hospitals is comprised of three branches, namely, Physical Therapy, Occupational Therapy, and Physical Reconditioning. Concurrently with the publication of this War Department circular, a War Department Memorandum was issued establishing a Convalescent Services Division in general hospitals. Certain activities originally established under Educational Reconditioning will be transferred to the Occupational Therapy Section. These activities are photography, typing, radio, drawing and sketching. Hospitals are authorized to employ civilian instructors qualified in these fields, if needed, to supplement the occupational therapy staff.

Major activities, which are an established part of occupational therapy, such as woodworking, printing, plastics, weaving, jewelry and metal work and ceramics, are to be expanded if necessary and the emphasis in all activities placed on the therapeutic value as administered on a prescription basis. It is felt that if diversional activities are of sufficient value to patients, it is important that they be properly prescribed by the physician for psychologically therapeutic purposes or for functional value.

Printing is authorized as an occupational therapy activity ONLY.

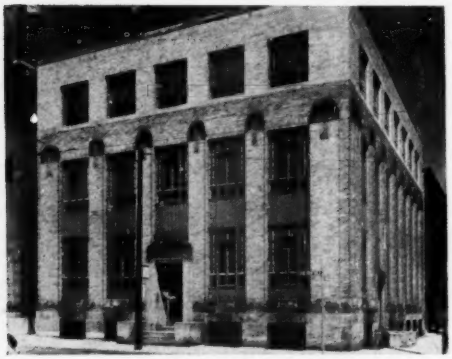
H. Elizabeth Messick, O.T.R.

SCHOOL SECTION

THE PHILADELPHIA SCHOOL OF OCCUPATIONAL THERAPY

419 South 19th Street, Philadelphia, Pa.

HELEN S. WILLARD, B.S., O.T.R., DIRECTOR



The Philadelphia School of Occupational Therapy was organized in the spring of 1918 under the auspices of the Central Branch of the National League for Women's Service in response to a call from the Surgeon General of the U. S. Army for Reconstruction Aides in Occupational Therapy to assist in the treatment and rehabilitation of men disabled in World War I. The first course, five months in length, was started that fall.

The School was incorporated under its own Board of Directors in 1923 and in 1930 moved into a building especially designed for it, located directly opposite the Hospital of the Graduate School of Medicine of the University of Pennsylvania. An affiliation was made with the Hospital so that the School has the advantage of its teaching facilities and maintains the Occupational Therapy Department in the Hospital as a training center.

The medical lecturers of the School, about thirty in number, are, for the most part, members of the teaching staff of the Graduate School of Medicine. Other lecturers are drawn from the social and educational agencies of the city. The twelve instructors of manual activities, several of whom are registered occupational therapists, are all experts in their fields.

In 1933 the School inaugurated the three year (26 months) diploma course which it still gives. A minimum of one year of post high school education is required for entrance to this course. Students who successfuily complete it may transfer their credits to the University of Pennsylvania and may attain a B. S. Degree in approximately one year of additional study. During the course two years of eight months each are spent in the study of medical subjects and manual activities and one year of ten months in clinical practice. Between the first and second years the student takes a one or two months period of orientation training.

An affiliation was made in 1941 with the School of Education of the University of Pennsylvania for the establishment of a five year course leading to a B. S. Degree. Approximately two years of this course consist of general college, study, including psychology, sociology and zoology, English, a foreign language, history and education. Two years are spent on specialization in occupational therapy, the content being the same as in the diploma course. The University of Pennsylvania awards the B. S. Degree at the end of the fourth year. The fifth year (ten months) is spent in clinical practice in various types of hospitals. Upon its completion the diploma of the School is awarded.

College graduates or persons with equivalent professional training, such as teaching or nursing, may be admitted on advanced standing and may attain the diploma of the School in eighteen months (eight months in the School, ten months of clinical practice).

The Curative Workshop occupies a part of the School building and offers opportunity, together with the Occupational Therapy Department in the Graduate Hospital, for the students to observe the treatment of patients early in their course. The Workshop treats for the most part cases of physical injury, fractures, burns, paralyses and the like. Considerable emphasis is laid on thorough grounding in this field. In the total period of clinical training

the student gains experience in all the major phases of occupational therapy.

The School has always met the standards of the American Occupational Therapy Association and its graduates are eligible to take the examination for registration given by the Association. In 1938 the School was accredited by the American Medical Association.

At the present time one hundred and thirty students are enrolled. Only a small proportion comes from Philadelphia or the vicinity. Students have come from England, Australia, India, Hawaii, Puerto Rico and Cuba, and from all over the United States.

Until 1944 an average of twenty-five students was graduated yearly. During the war emergency the courses were accelerated and the School participated in the training course sponsored by the Office of the Surgeon General of the U. S. Army. The School now has 954 graduates. Even during the depression years the School's graduates found positions without difficulty, and at the present time the demand far exceeds the supply.

UNIVERSITY OF TORONTO

Toronto, Canada

HELEN P. LEVESCONTE, O.T.R.
Supervisor, Course in Occupational Therapy

The request that a history of the Canadian Course in Occupational Therapy should appear in the first issue of the new journal of the American Occupational Therapy Association has touched us deeply. It was one of those gestures which proclaim more clearly than any formal statement, the good will that exists across our border. It is significant of the attitude and vision of fine members of a fine profession, who recognize no boundaries in their professional horizon.

That World War I gave Occupational Therapy its great impetus, is particularly true in Canada, for it was in those years that the first training course was given at Hart House, University of Toronto. The outline of this course was drawn up by a committee of members of the Faculty of Applied Science and Engineering, in fact, some of the classes were held in the Engineering Building. The first course was of six weeks' duration only, the succeeding courses were extended to three months. They included a large number of manual skills and some lectures in elementary anatomy, psychology and hospital etiquette. The skill acquired by these first "war aides," as they were called, is evidenced by the fact that they soon became known as "vocational aides."

Some 300 girls were trained during 1918-19, and sent to the military hospitals across Canada, in which they were employed as civilians under the Department of Soldiers' Civil Re-establishment.

By the year 1925, the ranks of these "war aides" had been thinned to such an extent by matrimony, that the need for trained therapists was becoming urgent. Now the doctors assumed the leadership, strongly supported by the Ontario Government, which was keenly aware of the need of expanding Occupational Therapy in the Provincial mental hospitals.

In 1926, the Canadian Association of Occupational Therapy was founded, a registry established, and professional standards set up. As President of this Association, Dr. Goldwin Howland approached the University of Toronto, asking that a two-year diploma course be established. In September, 1926, 24 students were enrolled in this new course, for which University entrance qualifications were required, and a diploma was granted by the University.

This course was set up under the Department of University Extension. This gave it the advantages of the teaching and other facilities of the various faculties of the University, and the freedom to develop and organize along its own professional lines. Under the understanding and sympathetic leadership of Dr. W. J. Dunlop, Director of the Department of University Extension, it has been possible, from

the beginning, to build up a course in terms of its professional requirements, and to secure the very best of University teaching according to our specific needs, rather than simply being included in established lecture courses of other groups. While this Department has no permanent teaching centres of its own, each course is set up according to its particular needs. All faculties of the University from which instruction has been requested, have been most generous in providing for us the best of their teaching. Thus we may say, our students are found wherever the University teaching of a subject is given — in the laboratories of the Anatomy Department, the gymnasium of the School of Physical and Health Education, the manual training rooms of the College of Education.

The first advance in the professional requirements of training came in 1931, when the Canadian Association established six months' internship following the completion of the two-year course. This was in addition to the two months' internship between the first and second years and practical work during the senior year which had been included in the original course. Thus we may say, that since 1931, training in Occupational Therapy in Canada has required sixteen months academic training at the University, and eight months clinical training in the practical field.

In 1933-34 the first survey of Occupational Therapy Schools and courses was carried out by the Council on Medical Education and Hospitals of the American Medical Association. On the completion of the survey, minimum standards of training were established by the Council, and the Course in Occupational Therapy, University of Toronto, was listed among the original six approved schools.

During the period preceding World War II, our registration had been restricted in numbers, and had varied from a total of 35 students in the combined two years, to a total of 70. With the outbreak of war and the anticipated need for occupational therapists, it was decided to cancel restriction of the number of students accepted for training, rather than establish additional courses. Hence our numbers increased seemingly without bounds. From a total in 1940 of approximately 56 students we jumped to 90, then to 135, to 210, and this year we have 245 undergraduate students.

This increased number of students necessitated increase in the teaching staff, especially of instructors who were experienced occupational therapists. This increase of therapist staff made possible the co-ordinated teaching we had striven for through the preceding years. The time allotted to the subjects taught by these instructors was redivided, to include the teaching of the techniques along with their application. Thus from her first introduction to the subject, the student is made conscious of the correlation of theoretical and practical subjects. She learns each in terms of its application, rather than first acquiring a standard skill which she discovers later she must use in an adapted form.

We are convinced that one of the most important advances we have made is in having a therapist instructor act as an assistant to the instructor in each of the Therapeutic Occupation classes. This provides for more demonstrations and individual assistance, the more immediate clearing up of difficulties, and immeasurable saving of time. Also, it has demonstrated that an instructor with an assistant can provide far better instruction to a class even double the size of one she could manage alone.

As a descriptive outline of the content of the Course is available in the curriculum published by the University, it is unnecessary to list the subjects here. However, two subjects do warrant special comment and explanation, one of which we have chosen as the subject of the photograph. These subjects are:

Remedial Games: During the recent war the increased lecture room space made available to us for the larger classes made it possible to formally include this subject in the Course. The use of games of a physically active nature as a tool of treatment, had steadily increased in the years preceding the war, but until more space was available to us they could not be included in the curriculum in their practical form. The development and adaptation of what are now termed "Remedial Games" in the treatment of restoration of physical function is a development of which we in Canada are justly proud. Much of this work was carried out at the Workmen's Compensation Clinic in Toronto, and prior to the war this was our medium of observation for the students. We

realized, however, that observation was not enough. Because, like any other tools of treatment, there are definite indications and contra-indications for their use, it was desirable to include them as a subject, rather than having the student simply acquire her knowledge of them in the practical field. This course is presented with two objectives:

1. To familiarize the student with the general rules and methods of playing the games.
2. By having the student play each game for a definite period of time, following which she makes an analysis of her physical reactions, she will get the "feel" of the game, and be conscious of such factors as fatigue, etc.

Remedial Gymnastics: This subject was inintroduced into the curriculum in 1934. The instructor is a physiotherapist. We consider the subject important, and our graduates tell us that it has been most valuable to them. As the function of the occupational therapist is to have her patient progress from the level of mechanical exercise to that of voluntary purposeful movement, it is necessary that she have a definite understanding of the exercise field, if she is to maintain continuity of treatment. In addition, there are some cases in which the occupational therapist must meet her patient on the mechanical level and therefore she must be trained to do so intelligently. Similarly there are cases in which the physiotherapist realizes the necessity or advantage of gaining or maintaining her patient's cooperation by turning her exercises into games because of their psychological value.

Last spring the University announced the addition of a third academic year to the existing course. This allows for better continuity of related lectures, clinics and theory. More time is allowed for some subjects which was badly needed, and some new material has been added.

It should be noted that our admission requirements (Grade XIII or Honour Matriculation or Upper School) mean that an applicant must have completed what is known in the United States as "the first college year." So three years in Canada is equivalent to four years in the United States!

Revision and re-evaluation of the content of each subject is made yearly and changes made in terms of professional developments or emphasis. We have done considerable experimenting and we shall continue to do so. In 1926 we started as a two-year course in which all subjects in the course were related to professional training. We have kept that fundamental concept throughout. Our concern through the years has been to have every subject presented in such a manner that the student is conscious of the professional approach from the beginning. The therapeutic interpretation and appreciation of every subject is essential. This is the problem on which we are still working and in which we believe we are on the road to success.

Space does not permit of the story of our own occupational therapy quarters on the University campus. It is one of many, often dramatic changes. Suffice it to say, that this year has brought at least temporary ending to our wanderings.

In conclusion may I remind you of one more historical point. When our first training of occupational therapists was given in Canada in 1918, it was one of your great therapists, Miss Brainerd, who came to Canada to assist in that course.

STUDENT COLUMN

Editor — Helen Harvey

The following is a selected excerpt from The Student Bulletin published by the Occupational Therapy Club at Milwaukee-Downer College. It so graphically describes undergraduate days that the editors believe it will provide a good moment and a pause for thought, not only to students but to those who wear O.T.R. on their sleeves. It is the hope of the editors that this section of the Journal will contain not only Bulletin excerpts, but contributions from occupational therapy students. The Journal wishes to present the thinking of those who *will* be O.T.R.s as well as those who *are* O.T.R.s.

Fiercely gripping the subway strap in my teeth, clutching my neuro-anatomy book in a half-nelson, and desperately wishing I had started for Theory fifteen minutes earlier, I am trying to say "hello" to all of you from the Columbia University O.T.'s.

On September 26th, 1946, a fresh new class of occupational therapists started their two year degree course at

(Continued on Page 56)

SURVEY OF SCHOOLS OFFERING COURSES IN OCCUPATIONAL THERAPY
JANUARY, 1947

Name of School	Name and Address of Director	Type of Course	Entrance Requirements	Classes Start	Length of Course	Students M	Students F	Graduate in 1946
Boston School of Occupational Therapy Affiliated with Tufts College—School of Education	Mrs. John A. Greene, Pres. Boston School of Occupational Therapy, 7 Harcourt Street, Boston 16, Massachusetts	a. Advanced Standing (Diploma)	*College degree or accredited professional training	Sept.	Approximately 20 months	No	Yes	13
		b. Degree (B.S. from Tufts plus B.S.O.T. diploma)	Secondary school diploma or qualified transfer students	Sept.	Approximately 44 months	No	Yes	
Columbia University College of Physicians and Surgeons	Miss Marjorie Fish, OTR Director of Training Courses in Occupational Therapy Columbia University, College of Physicians and Surgeons, 630 West 168th St., New York 32, New York	a. Degree (B.S. in O.T.)	*2 yrs. college	Sept.	25 months	Yes	Yes	7
		b. Certificate from Medical School	*A.B. or B.S.	Sept.	17 months	Yes	Yes	19
†Iowa, State University of College of Liberal Arts and College of Medicine	Miss Marguerite McDonald, OTR Occupational Therapy Supervisor Division of Physical Medicine College of Medicine State University of Iowa Iowa City, Iowa	a. Degree (B.S. from College of Liberal Arts)	Entrance requirements of the university	Sept. Feb.	36 months	Yes	Yes	
		b. Certificate from College of Medicine		Sept. Feb.	The above plus 9 mo. clinical training			
Illinois, University of College of Medicine	Miss Beatrice D. Wade, OTR Associate Professor Department of Occupational Therapy, University of Illinois 1853 West Polk Street Chicago 12, Illinois	Degree (B.S. in O.T.)	*High school graduates upper 50% of class	Oct. Feb.	40 months	Yes	Yes	15
Kalamazoo School of Occupational Therapy Affiliated with Western Michigan College of Education	Miss Marion R. Spear, OTR Associate Professor Director of Occupational Therapy Kalamazoo School of Occupational Therapy Western Michigan College of Education Kalamazoo 45, Michigan	a. Degree (B.S. with major in O.T.)	30 semester hrs. of college credits	Sept. Feb.	Approximately 29 months	Yes	Yes	9
		b. Diploma	As above	As above	25 months	Yes	Yes	5
		c. Certificate	Degree	As above	18 months	Yes	Yes	5
Kansas, University of School of Occupational Therapy	Miss Nancie B. Greenman, OTR Assistant Professor Director of Occupational Therapy University of Kansas Lawrence, Kansas	a. Degree (B.S. in O.T.)	Accredited Kansas High School graduate	Sept. Feb.	42 months	Yes	Yes	10
		b. Certificate	*College degree	Sept. Feb.	21 months	Yes	Yes	
Michigan State Normal College	Miss Gladys Tmey, OTR Assistant Professor Supervising Director of Occupational Therapy Michigan State Normal College Ypsilanti, Michigan	Degree (B.S. with major in O.T.)	*Entrance requirements of the college	Feb. June Sept.	45 months	Yes	Yes	8

SURVEY OF SCHOOLS OFFERING COURSES IN OCCUPATIONAL THERAPY

Ypsilanti, Michigan

SURVEY OF SCHOOLS OFFERING COURSES IN OCCUPATIONAL THERAPY
JANUARY, 1947

Name of School	Name and Address of Director	Type of Course	Entrance Requirements	Classes Start	Length of Course	Students M	Students F	Graduate in 1946
Mills College	Miss Arlene J. VanDerhoef, OTR Director of Occupational Therapy Mills College Oakland 13, California	a. Degree (B.A.)	Entrance requirements of the college	Sept. Feb.	4 yrs. plus 36 wks. clinical training	No	Yes	7
		b. Certificate	Degree from accredited college	Sept. Feb.	3-4 terms	No	Yes	1
Milwaukee-Downer College	Prof. Henrietta McNary, B.S., OTR Director, Department of Occupational Therapy Milwaukee-Downer College 2512 East Hartford Ave. Milwaukee, Wisconsin	a. Degree (B.S. with major in O.T.)	*Graduates of accredited high school	Sept.	46 months	No	Yes	24
		b. Diploma	*As above plus 1 yr. college or professional training	Sept.	28 months	No	Yes	5
†Minnesota, University of School of Medicine	Miss Borghild Hansen, OTR Director of Occupational Therapy University of Minnesota Minneapolis, Minnesota	Degree (B.S. in O.T.)	*High school graduate plus 2 yrs. in Arts college	Oct.	39 months	Yes	Yes	
Mount Mary College	Sister Mary Arthur, OTR Associate Professor Director of Occupational Therapy Mount Mary College Milwaukee 13, Wisconsin	a. Degree (B.S. in O.T.)	Accredited high school graduate	Sept.	45 months	No	Yes	10
		b. Certificate	*College degree	Sept. Feb.	Variable	No	Yes	
New Hampshire, University of College of Liberal Arts	Miss Doris F. Wilkins, OTR Supervisor of Occupational Therapy Curriculum University of New Hampshire Durham, New Hampshire	a. Degree (B.S. with major in O.T.)	*High school graduate	Sept.	32 months	Yes	Yes	
		b. Certificate of Proficiency			The above plus 9 months	Yes	Yes	7
New York University School of Education	Miss Frieda J. Behlen, OTR, M.A. Director of Occupational Therapy Curriculum New York University Washington Square New York 3, New York	a. Degree (B.S.) and Certificate	*High school graduate	Sept. Feb. June	42 months	Yes	Yes	17
		b. Certificate	One year college		32 months	Yes	Yes	2
Ohio State University College of Education	Miss Martha E. jackson, OTR Associate Professor Chairman, Occupational Therapy Department 105 Arps Hall, Ohio State University Columbus 10, Ohio	a. Degree (B.S. in O.T.)	High school graduate	Sept.	39 months	Yes	Yes	28
		b. M.A.	OTR with college degree	Sept. Feb. June	9 months	Yes	Yes	

SURVEY OF SCHOOLS OFFERING COURSES IN OCCUPATIONAL THERAPY
JANUARY, 1947

Name of School	Name and Address of Director	Type of Course	Entrance Requirements	Classes Start	Length of Course	Students M	Students F	Graduate in 1946
Philadelphia School of Occupational Therapy Affiliated with University of Pennsylvania—School of Education	Miss Helen S. Willard, OTR Director, Philadelphia School of Occupational Therapy 419 South 19th St. Philadelphia 46, Pa.	a. Degree (B.S. from University of Pennsylvania) plus diploma of P.S.O.T.	*High school graduate	Sept. Feb.	42 months	No	Yes	2
		b. Diploma	*1 year college	Sept.	26 months	No	Yes	7
		c. Advanced Standing	*College degree or professional training	Sept.	18 months	No	Yes	27
Pennsylvania, University †(See Philadelphia School of Occupational Therapy)								
†Puget, College of	Miss Edna-Ellen Bell, OTR Director of Occupational Therapy and Rehabilitation College of Puget Sound North 15th and Warner St. Tacoma 6, Washington	a. Degree (B.S. with major in Biology)	High school graduate	Sept. Jan.	45 months	Yes	Yes	1
		b. Certificate	Transferred credits from approved college	Sept. Jan.	27 months	Yes	Yes	
†Saint Catherine, College of	Sister Jeanne Marie, OTR Director of Occupational Therapy The College of St. Catherine St. Paul 1, Minnesota	Degree (B.S.)	*Special	Sept. Jan. March	36-45 months	No	Yes	1
San Jose State College	Miss Mary Booth, OTR Assistant Professor in Occupational Therapy San Jose College San Jose 14, California	a. Degree (B.A.)	High school graduate	Oct. Jan. April	45 months	Yes	Yes	10
		b. Certificate	College degree		18 months minimum	Yes	Yes	1
Southern California, University of College of Letter, Arts and Sciences	Miss Margaret S. Rood, OTR Head, Department of Occupational Therapy University of Southern California Box 274, Los Angeles 7, California	a. Degree (B.S.) plus certificate	*High school graduate (upper ½ of class)	Sept. Feb. July	45 months	Yes	Yes	7
		b. Advanced Standing (CTF)	College degree	As above	18 months	Yes	Yes	56
		c. Graduate (M.A.)	OTR or eligible for OTR with college degree	Sept.	9 months	Yes	Yes	
†Texas State College for Women Department of Art	Mrs. Fanny B. Vanderkooi, OTR Associate Professor Supervisor of Occupational Therapy Course Texas State College for Women Denton, Texas	a. Degree	High school graduate	Sept.	36 months	No	Yes	3
		b. Certificate	B.S. or B.A. with a major in O.T.	Feb.	9 months of clinical training	No	Yes	

SURVEY OF SCHOOLS OFFERING COURSES IN OCCUPATIONAL THERAPY

SURVEY OF SCHOOLS OFFERING COURSES IN OCCUPATIONAL THERAPY
JANUARY, 1947

Name of School	Name and Address of Director	Type of Course	Entrance Requirements	Classes Start	Length of Course	Students M	Students F	Graduate in 1946
Toronto, University of Department of University Extension	Miss Helen D. LeVesconte, OTR Supervisor, Course in Occupational Therapy University of Toronto Toronto, Canada	Diploma	Senior Matriculation	Oct.	32 months	No	Yes	81
Tufts College (See Boston School of O.T.)								
Washington University School of Medicine	Professor Sue P. Hurt, OTR (on leave) Miss Dorothy L. Flint, OTR Acting Director, Department of Occupational Therapy Washington University School of Medicine 4567 Scott Avenue St. Louis 10, Missouri	Degree (B.S. in O.T.)	Two years of college	Sept.	27 months	Yes	Yes	14
†Wayne University College of Liberal Arts and College of Education	Miss Barnara Jewett, OTR Assistant Professor Director of Occupational Therapy Wayne University Detroit 1, Michigan	a. Degree (B.S. in O.T.) b. Post Degree Certificate	High school graduate *College degree	Sept. Feb. June As above	4½ years 2 years	Yes	Yes	
Western Michigan College of Education (See Kalamazoo School of Occupational Therapy)								
William and Mary, College of Richmond Professional Institute	Miss Helen Freas, OTR Assistant Professor Acting Director of O.T. Training Course Richmond Professional Institute The College of William and Mary 901 West Franklin Street Richmond 20, Virginia	a. Degree (B.S. in Social Science) b. Certificate	2 years college 1 year college	Sept. Sept.	3 years 27 months	Yes Yes	Yes Yes	 28
†Wisconsin, University of School of Medicine	Miss Caroline Goss Thompson, OTR Assistant Professor of Physical Medicine Technical Director of Course in Occupational Therapy University of Wisconsin 1300 University Avenue Madison 6, Wisconsin	Degree plus certificate from School of Medicine	As for university (temporary limit—residents of Wisconsin) only	Sept. Jan.	33 months	Yes	Yes	8

*Schools having special additional requirements.

†Schools Pending Accreditation.

STUDENT COLUMN

(Continued from Page 51)

Columbia. The class consists of thirteen girls and one lone man. Many changes in the group have been seen in the few weeks we've been in session. Long bobs have disappeared, either with the help of shears or hairpins. Bobby socks have also been eliminated, and an air of decorum settles on the group when it crosses the threshold of The College of Physicians and Surgeons.

The experience that made the most startling impression on the group was the use of the cadaver in the Anatomy Laboratory. The reactions were varied but after the initial shock, all were friends with the specimen. After becoming acquainted, it was decided to name him—he has been christened Ernest (because we are all trying to work in dead Ernest!)

Also on that historical date of September 26th, the "Advanced Standing" arrived. "Standing" may have described the past condition of the class; they are now, however, transformed into "Advanced Flyings," for this athletic technique is required to hop from the magnificent approach of the soaring George Washington Bridge to that car-choked entrance of the subterranean Holland Tunnel, with casual stops for fueling mind and body.

A tightly packed schedule of classes from nine to six Monday through Friday, with an occasional field trip tossed in for dessert, demands streamlined mental digestion. The Advanced class has brought with it not only Bachelor's Degrees from twenty-one colleges, but also precious experience from the fields of merchandising, teaching, bacteriology, personnel, and Occupational Therapy in the Armed Forces. With the assistance of Uncle Sam, five Army veterans and four Navy veterans, and again one lone man, make up a little less than half the class.

In reaching Physicians and Surgeons, the class claims travel by subway from Brooklyn, bus from Queens, and trains from Long Island, Westchester, New Jersey, Rhode Island, Connecticut, Maryland, Massachusetts, Illinois, Wisconsin, Virginia, and sections of upstate New York.

While the 26th of September brought forth enthusiastic neophytes it also produced the second year students. Haggard and worn, the nine "professionals" returned from summer affiliations in mental hospitals. Now carefully looking their friends in the eye and mentally classifying each as to type, the "second years" felt well on the way; and so, with a knowing look talked to the uninitiated of the summer's experiences. It was SUCH an experience that one of the nine broke her leg. Yes, her story is that she was blueberry picking. (?) Meanwhile she is demonstrating to the rest the finer points of crutch walking.

With only nine, they are spread pretty thin between Printing, Radio, Machine Shop, Sheet Metal, Design, Theory, Neurology, Weaving, Surgery, and Medicine. And so, onward they go despite the fact that Medicine has them thinking they have every symptom in the book.

Oops! Have to catch class. Will write soon again.

THELMA WELLERSON
Class Editor '48

ALLIED PROFESSIONS

The very nature of occupational therapy makes it highly sensitive to the interests and progress of allied professions. The training of an occupational therapist should make her reasonably intelligent in following other professional developments without attempting to practice in fields for which she is not qualified. Of this she must take great care. Such supposed participation has brought some feeling of criticism in localized areas where the purpose was not understood.

For the fullest development of an occupational therapy program in an institution there needs to be more than the usual range of interdepartmental cooperation. It is not that occupational therapy needs the buoyancy of the other departments for survival; it is not that the occupational therapists care to or are capable of running the other fellow's job; and it is not that they have time on their hands for idle neighboring. The fact is that the program occupational therapy embodies is strengthened by the degree to which it becomes integrated as part of the whole institution or community structure.

The extent to which this is accomplished depends on the occupational therapist's understanding of the allied programs and her ability to guide the patient into activity that will be of greatest therapeutic value in view of the overall problem faced by the patient and the overall program available for his care.

Occupational therapy needs better interpretation to other services. This program provides the only opportunity for purposeful activity where the patient's own initiative and active efforts are guided for specific therapeutic development. Its value can be increased by serving as a laboratory in which working procedures are prescribed to develop or resolve symptomatic factors. In this it can be a constructive aid to allied professional programs. The occupational therapist has marked responsibility and unbounded opportunity in this respect.

The "any activity" scope of occupational therapy makes it appear diffuse and hard to catalogue. The solidity of the occupational therapist's concept of the patient problem and

therapeutic use of activity is the foundation of her work. This is not always apparent to the professional staff of other departments. Part of the need in the continued development of occupational therapy is the increased interpretation in tangible form of how procedure is planned and guided to meet the patient problem at the symptom level. We have been guilty of not providing sufficient evidence of the basic structure of our work. Others are inclined to view and understand the more tangible aspect of occupational therapy apparent in the activity itself. This is our fault and is for us to remedy.

"Any activity," as every occupational therapist knows, is the range through which she might reach to select the undertaking which will prove to be of most value to the development of the patient in meeting a medical prescription. Crafts are extensively used. Abstract play, play with toys, simple games, organized games, competitive games, exercise, sports, dramatics, puppetry, music, fine arts, home economics, industrial procedures, instructional procedures, gardening, collecting, study, dancing, social activities, use of mechanical apparatus, group work, vocational pursuits, counseling and conversation have all been used in varying degrees within the "any activity" category. This range touches upon the well developed pursuits of many allied professions. Occupational therapists need a better understanding and greater working knowledge of these allied professions to minimize a duplication of effort and correlate service programs so each can proceed within its own purpose. Greater understanding will enable the occupational therapist to encourage the development of an allied service, where there is such need, and dovetail the working relationship of both services within an institution or community program.

Greater understanding on the part of the occupational therapist can increase her own useful range of techniques without overlapping or infringing on other programs. It may be necessary to adapt or vary the techniques. The singular job of the occupational therapist is to further such procedure in direct relation to the patient's disability with immediate bearing on the physical and emotional symptoms in line with the medical plan of treatment. As always, her program is under prescription as therapy.

The occupational therapist's keen awareness of developments in other fields is a basic part of her job. It is the purpose of the section on Allied Professions in The American Journal of Occupational Therapy to introduce and develop information from other fields. Through their professional organizations, publications and consultant services much helpful guidance is available. There is extant a growing expression of willing cooperation and mutual respect. We must respond to this good will, recognize the opportunity and make a substantial interprofessional contribution.

SPECIAL NOTICES

1947 NATIONAL CONVENTION

November 2-November 7
Hotel del Coronado
Coronado, California
Across the Bay from San Diego

Board and Committee Meetings—
October 31-November 1
Convention—November 2-November 5
Institute—November 6-November 7

NATIONAL REGISTRATION EXAMINATIONS

On the basis of the recent survey of prospective applicants for the Registration Examination for the year 1947, for all schools of occupational therapy the following dates are announced:

Friday, June 27
Friday, October 24

The usual notice will be sent the schools two months in advance of each examination.

OCCUPATIONAL THERAPISTS OF WORLD WAR II

All registered occupational therapists who served in Army or Navy hospitals in World War II in the United States and Canada, who have not received copies of the Newsletter of Occupational Therapists of World War II are requested to write to Miss Erna Rozmarynowski, O.T.R., Route 1, Pewaukee, Wisconsin. Send her your present address so you will receive the current issue.

Susan S. Barnes, O.T.R., President

OCCUPATIONAL THERAPIST WANTED FOR:

F. D. Roosevelt Rehabilitation Institute
(the Czechoslovak Warm Springs) in
Janske Lazne, Czechoslovakia

This is a state institution—it was begun in 1935 and has been growing since the war. Occupational therapy will be financed by Red Cross. It is a 120-bed hospital with an out-patient clinic. Sub-acute and chronic poliomyelitis, cerebral palsies, peripheral nerve injuries.

Occupational therapist wanted to be at work by August 1, 1947. Knowledge of language helpful but not specified for position.

Apply to Mr. Melvin A. Glasser, Assistant Director International Activities, American Red Cross National Headquarters, Washington 13, D. C.

The above request was urgently made in person by the doctor in charge of the institution on a visit to our national office in December.

TO ALL GRADUATES OF WAR EMERGENCY COURSE

There has been some misunderstanding about your qualifications under Civil Service. The standard qualification for an occupational therapist, professional rating as established by Civil Service, is graduation from an accredited school. As you were all graduated from an accredited school which issued you a diploma, there is no reason to question your qualifications. Graduates are qualified for appointments as staff therapists or for supervisory positions, depending upon experience.

The grade is allocated to the job and not to the person assigned to it, and it may be possible that a person who can qualify through experience for a higher grade is asked to accept a position at the lower grade because that is the only job open. When this happens opportunity for advancement is possible as the job develops more responsibility. This in turn will call for reallocation of grade. In Civil Service, as in all work relationships, advancement should be a result of achievement.

Jane E. Myers, O.T.R.
Chief, Occupational Therapy
Veterans Administration

OCCUPATIONAL THERAPISTS IN THE CARDIAC FIELD

There is a definite need for a list of occupational therapists who are engaged in programs for the cardiac patient in both the adult and the pediatric field. It is the aim of the Cardiac Division Editor of *The American Journal of Occupational Therapy* to bring this group together and to pool its thinking for the O.T. Clinic Column, for O.T. Items, and for papers on cardiac disabilities.

Outlines of programs, size of hospital, number of cardiac patients treated, size of O.T. staff, and names of other staff members in the hospital who are engaged also in the cardiac program, may be sent to Miss Susan S. Barnes, 527 North and South Road, University City 5, Missouri. These contributions will provide the beginning for a list which will be published later in the Cardiac Column. A deadline of two weeks after receiving this issue has been set for obtaining this material.

Susan S. Barnes, O.T.R.

MASTER'S CURRICULUM AT USC

The Master's curriculum for Occupational Therapy has been approved by the Graduate Council of the University of Southern California. Previously it has been a division major in the Division of Health, Physical Education and Therapy with the degree being awarded by the Physical Education Department although work taken was Occupational Therapy. Orthopedic work only is offered at this time. The new curriculum leading to an M.A.:

	Semesters I	Semesters II
P.T. 169x Anatomy and Kinesiology for Therapists)no graduate credit but prerequisite for Master's study unless student has had P.T. 169a or equivalent)	3	
O.T. 202 Orthopedic Application	2	
O.T. 259 ab Practicum in Occupational Therapy	2	2
O.T. 260 ab Special Problems	2	2
O.T. 261 ab Thesis Work	2	2
*O.T. 171 Advanced Kinesiology		2
*O.T. 140 Neurology	1	
*O.T. 175 Equipment, Theory and Laboratory		2
Electives	4	5
	16	15

*Carry graduate credit

Suggested electives if your interest is:

INDUSTRIAL THERAPY
P.E. 202 Individual Differences in Motor Skills (2)
Management 142 Personnel Tests and Rating Scales (2)
Management 176 Time and Motion Study
Economics 104 Labor Legislation
Psych. 163 Industrial Psychology
Pub. Adm. 122 Procedural Planning for Supervisors (2)

PEDIATRICS
P.T. 210 Therapeutic Program for Cerebral Palsies
Educ. 131 Growth and Development of the Child
Soc. 164 Children's Behavior Problems

GENERAL ORTHOPEDICS
P.E. 168 Body Mechanics
P.T. Muscle Testing

GENERAL ELECTIVES
Fine Arts
Crafts
Philosophy
Literature

O.T.'S NEEDED IN PALESTINE

"Urgently needed for Palestine four trained Occupational Therapists to head units in the mental tuberculosis and orthopedic fields and also assist in clinical training of students. Offers unusual possibilities and experiences. A knowledge of Hebrew desirable. For further details communicate with Hadassah, the Women's Zionist Organization of America, 1819 Broadway, New York, N. Y."

EVENTS CALENDAR

MARCH 15-17, 1947

AOTA Board Meeting, Philadelphia School of Occupational Therapy.

APRIL 12, 1947

Eastern Section—American Congress of Physical Medicine, Polyclinic Medical School and Hospital, New York.

APRIL 29-30, 1947

National Council on Rehabilitation, Jefferson Hotel, St. Louis, Mo.

MAY 1-3, 1947

National Rehabilitation Association, Jefferson Hotel, St. Louis, Mo.

JULY 6-12, 1947

American Physiotherapy Association Conference, Asilomar, Pacific Grove, Calif.

NOVEMBER 2-7, 1947

Annual Convention of the American Occupational Therapy Association, Hotel del Coronado, Coronado, Calif.

O.T. CLINIC AND CASE STUDIES

At one time or another most therapists have felt the need of counsel concerning specific patient treatments, or about difficulties experienced in hospital programs. To meet this need, at least in part, this column is being inaugurated. We hope it will serve as a clearing house for questions and answers.

Questions may be sent to the editor who in turn will relay them to those best qualified to answer them accurately. We hope that some answers or questions will draw forth written comments from the membership. In this way we believe that much valuable information may be made available to the field at large, and at the same time an opportunity will be provided to observe problem trends.

This question was sent from a large general hospital and concerns the treatment of Arthritis. The question was written to one occupational therapist by another, and the answer should be regarded as but one opinion, albeit a careful and considered one based upon experience.

Question 1: When an arthritic is a chronic Osteo-arthritic, and is quiescent as to symptoms, pain, etc., do the patients force motion beyond their present range, do they work just within their range of motion, or can outside force be applied? Is it correct to use sand blocks to force such motion?

Question 2: Do you think a patient who is having some swelling, pain, and inflammation should be allowed to work, and if so, should he be put back a class or two?

Answer: As to the first question, I feel that any force which the patient applies himself is perfectly safe. With osteo-arthritis some force is usually necessary to increase motion, and may be given if pain and swelling are not present in any marked degree. However, I have never approved of using outside force in treating any type of arthritis. For instance, the use of sand blocks which force fingers into position of flexion maintained by strapping the hand in place results merely in a holding position. Active motion is greatly to be preferred as it not only increases the range of motion, but begins by strengthening muscles which show an atrophy from disuse.

If of course the actual breaking up of adhesions is necessary to free the joint, then you must be sure that whatever force is applied is specifically ordered by the doctor, and even then it is best done by the doctor himself. Sometimes such force may be applied, to knees, for example, by using the bicycle jig saw. In this case the momentum of the saw plus the patient's own body weight and muscle strength will give the desired results. But here again the patient himself applies the force—it should not be done by the therapist.

As to the second question, I happen to be one of the people who believes in exercise to an arthritic joint, during the stage when some pain and swelling are still present. There has always been some controversy on this point and disagreement even between doctors. Many people feel that to wait until all pain and swelling has subsided is to invite adhesions and limitation of motion, and that the task of obtaining motion is then more difficult, more painful and takes twice as long as would have been necessary had gentle exercise been prescribed during the early stage of the disease. Of course, during the acute stage of the disease absolute rest to the joint is essential. When exercise is begun, always watch for any increase

in heat, redness, pain or swelling and discontinue exercise if any of these symptoms recur to any marked degree.

I believe exercise should be graded at first from as little as ten minutes a day to half an hour. It may be some time before the patient can tolerate even forty five minutes a day. I do not know just what your classifications are, but usually therapists are inclined to grade treatment for arthritics too rapidly. It is better to make very slow but steady progress, thus avoiding sudden flare-ups, and the necessity for cutting down a patient's work period. The latter is most discouraging for him, as well as being dangerous to the joint.

PREFRONTAL LOBOTOMY

Psychiatrists have for many years understood how many normal and abnormal mental mechanisms arise. They have also understood that both the normal and the abnormal mental reactions must take place through the pathways laid down in the structure of the human nervous system.

Thinking and feeling are human reactions of which we are all aware. We are sometimes inclined to consider these functions as independent of the body in which they take place. The complexity of a simple reaction like that of observing a desired object, forming the will to get it, then getting up and obtaining it, achieving a sense of pleasure in the action and a relief of the mild tension set up by the perception and the wish, make it difficult to express and understand just how this takes place in the nervous system, when one realizes that literally millions of nerve fibers must react and interact with each other to achieve this relatively simple maneuver. The complexities of ordinary thinking are far more involved.

None-the-less, it has been known that certain portions of the brain are more involved in the production of disturbed emotions and the accompanying disturbed thinking.

Prefrontal lobotomy was first carried out in 1935 by Moniz and was called "leukotomy." It was adopted in the United States the next year by Freeman and Watts and the operation has been refined and improved until now it has become fairly standardized. By this method, it is possible to separate the connections between one part of the brain, which has to do with complicated thinking, and another part, which has to do with emotional reactions, and to break up the poor co-ordination between the two.

Several hundred patients have now been operated on and a number have been observed over periods as long as ten years. In cases for which it has been found suitable, improvements have been striking. It now offers a hope for a good many mental conditions which have heretofore been considered as hopeless, though we are not yet sure of just how much we can expect of this procedure. We are sure of the fact that like most treatments of mental conditions, it cannot stand alone, but must be accompanied by attention to all aspects of the patient's life; most particularly those patients who have been ill and in poor contact with the world for many years must have renewed and intensive efforts at re-orientation to life.

At Middletown, four patients have now been operated on and more will be done in the future. The progress these four have made in a very short time, gives us cause for a considerable hope for many others.—Benjamin Simon, M.D., Connecticut State Hospital, Middletown, Connecticut. *Reprint from "THE SCRIBE."*

Interesting observations in post-lobotomy care with occupational therapy and recreational therapy procedure:

Patient A - Age 47 years; single; diagnosis, psychoneurosis, psychasthenia. Date of admission, October 1941. Condition prior to operation: compulsive, suicidal tendencies, fear of killing her loved ones. Tense and anxious. Facial expression one of concentration. Depressed and worried over own mental state. Allowed home visits, but was unable to adjust satisfactorily and returned to hospital. Failed as worker in dietary department, but was capable of helping with ward work occasionally. At times would cry and shriek so that seclusion was necessary. Smashed windows and threatened suicide and finally escaped June 1946. Returned to hospital next day by sister-in-law.

Lobotomy operation performed October 1946. Progress following operation. Uneventful p. o. recovery. The only evidence of her former destructive and fearful self she preserves is a certain fixed smile and over-eagerness.

First month: exhibits good judgment in activities; placed in charge of clothing room on one of the wards, and takes patients to cafeteria. Pleasant, cheerful attitude; very neat and attractive appearance, and most cooperative in occupational therapy classes. No feelings of hostility or indecision are manifested. Interest good; very sociable; accomplishes average amount of work; plays piano well; shows more spontaneity than formerly in socializing with the ward group.

Expected outcome: a boarding home for patient to reside, and a refresher course in commercial subjects at some business school.

Patient B - Age 29 years; single; diagnosis, dementia praecox, hebephrenic. Date of admission, August 1943 (three previous admis-

sions in private sanitorium). Condition prior to operation: seclusive and preoccupied; careless in appearance. During menstrual period she was overactive, impulsive, assaultive. Loud singing; hallucinations; delusional ideas which could not be elicited because of inaccessibility. Untidy, destructive, and denudative. Attempts to interest her in occupational therapy futile.

Lobotomy operation performed October 1946. Progress following operation. Overactive and disturbed during the first post-operative days; required sedation. This phase subsided and patient improved greatly, exhibiting only mild confusion; she became quiet and relaxed. She has shown considerable initiative in caring for herself; no urinary incontinence, no episodes of disturbance. Work performance shown in occupational therapy class was very good, but she needed constant encouragement to increase her interest span. Very neat with her work and personal habits.

Physician's notes: "She has not shown the retardation and lack of spontaneity that a number of lobotomies have shown; instead has been active and interested in things and has kept up her personal appearance, and taken an active interest in recreation. In talking with her one realizes certain mental vacuities which seem to be due to emotional attitudes rather than any innate factor."

Final outcome: home visit for one year, December 1946.

Patient C—Age 26 years; married; three children; diagnosis, psychoneurosis, mixed type. Date of admission, January, 1945.

Condition prior to operation: extreme outbursts of homicidal nature; terrific desire to do away with herself and her children. Confused, mixed-up; continuous crying, several suicidal attempts. Tense and anxious. Home visit, May 1945; fair adjustment until her return to hospital Jan. 1946, when she became hysterical, screaming and crying; outbursts of rage and suicidal impulses. Upset the whole ward routine with swearing and loud talking.

Prefrontal lobotomy performed June 1946. Uneventful post-operative recovery. Emotional tone care-free; no outbursts of rage. Attitude and conduct friendly, pleasant, memory good; well-oriented.

Progress in occupational therapy class: spasmodic attention; alternately confused and lucid; scattered conversation; showed keen interest; good ability; selected her own handwork; gradual improvement in completion of tasks.

Six weeks following operation: taking part in games, friendly, cooperative; neat and clean appearance; occasionally hyperactive, and placed away from the group to play the piano or work by herself.

Final outcome: "Steady improvement in all spheres; lackadaisical sort of distractible individual. When there is an emotional incentive she accomplishes things very well," physician's report. Home visit, July 1946, for one year. Social worker's visit found the home reasonably clean. November, 1946, clinic visit; patient was cheerful, and appeared to be getting along well.

* * *

These cases have been observed at the Fairfield State Hospital, Newtown, Connecticut. Occupational therapy enters into the post-operative care of the lobotomy patient as a logical sequence in the course of treatment. It offers a stimulus and incentive at this moment when the patient's attention should be directed toward constructive, interesting activity, under careful supervision, as she regains strength. It provides the psychologic uplift that is very necessary as the patient progresses through a process of re-education in her habits of living, having come through the operation and attained better emotional balance and keener contact with reality.

BERTHA J. PIPER, O.T.R.

One of the problems faced by many occupational therapy departments is the lack of cooperation from the medical staff. May we see answered in the Occupational Therapy Clinic Column some definite steps therapists have made to acquaint doctors with the purpose of an occupational therapy program and to solicit their cooperation and support.

L. C. M.

What are the most important points to stress in organizing an Occupational Therapy Department? A given problem with one solution.

Situation: Establishment of a new occupational therapy department which is already a going concern. Specific exercise to injured

parts has been taken care of by Physical Therapy and diversional activities by well-meaning but unguided volunteers.

Problem: To show the hospital staff that Occupational Therapy fits into and is a necessary part of the established plan.

Method of Solution:

1. Survey made of hospital patients to determine types and numbers of diagnoses.
2. Priority plan drawn up for treatment of each type showing how functional treatments for both mental and physical disabilities take precedence over diversional.
3. Plan presented at staff meeting following a well illustrated lecture stressing certain points.
   a. Value of Occupational Therapy plus Physical Therapy as soon as active exercise is indicated.
   b. Value of Occupational Therapy for neuropsychiatric patients as diagnostic aid and definitive treatment.
   c. Necessity for prescriptions properly completed.
   d. Importance of supervising and planning program for volunteers.
4. Open house in the Occupational Therapy clinic for demonstration of equipment.
5. Participation in ward rounds and clinics.

Rhoda Lester, O.T.R.

Do other therapists find psychiatric diagnoses of value in planning treatment?

Diagnosis is omitted from our prescription form at the request of our psychiatrists who feel that the prescriptions produced by the diagnostic label would limit our view in such a way that we might miss valuable openings for therapy. . . . The case histories are available to us and we have opportunity to discuss therapy with the doctors, but discussion is oriented toward the individual problems of the patient, not toward diagnosis. The few cases we see involving organic factors provide the exception to this rule, for we are notified immediately if organic lesion is suspected.

Working on this basis we miss diagnosis so little that I wonder whether it can actually serve any function in psychiatric occupational therapy. The one place, other than organic, where it occurs to me that it might be useful is with catatonic patients when it is advisable to be on guard for sudden periods of excitement. Even there it seems to me, it is of little avail to know the dangers as indicated by the diagnosis, if one is not competent to observe and interpret the tension in the patient and if one can do that, one does not need the diagnosis.

I shall be very glad to hear from other occupational therapists what use, if any, they make of psychiatric diagnoses.

Elizabeth P. Ridgway, O.T.R.

Do You Know That . . . .

WARM SPRINGS RESEARCH PROGRAM

The Georgia Warm Springs Foundation is interested in evaluating the specific place of occupational therapy in the care of convalescent as well as pre- and post-operative poliomyelitis. Their particular interest is to determine a specific integration between physical therapy, occupational therapy, and recreational therapy in poliomyelitis. To this end, a project has been initiated January 1st through a grant from the National Foundation for Infantile Paralysis. The objectives of this program are:

(1) To determine and demonstrate the value of functional occupational therapy in poliomyelitis.

(2) To determine and demonstrate proper integration of functional occupational therapy with physical therapy and recreational therapy in the care of poliomyelitis.

(3) To set up a manual on "Functional Occupational Therapy in Poliomyelitis."

(4) To initiate graduate study in functional occupational therapy in poliomyelitis.

BCG VACCINE BEING STUDIED

At a conference of outstanding leaders in tuberculosis from the United States, China, and Denmark, Dr. Herman E. Hilleboe, Chief, Tuberculosis Control Division of the U. S. Public Health Service, reviewed the past experience with BCG, named bacillus of Calmette and Guerin for the French scientists who discovered it. Dr. Hilboe pointed out that the vaccine has been extensively used in Europe and South America in artificial immunization against tuberculosis and that research on this

subject has been undertaken in the United States by competent investigators.

From studies presented at the conference, it appears that BCG vaccination confers increased resistance for the limited period covered in these studies but it is not 100% effective. There have been no proved cases of progressive disease resulting from BCG vaccination and it can be used without causing severe local reactions.

The U. S. Public Health Service, Federal Security Agency, will extend its tuberculosis research program to include studies on the effectiveness of BCG vaccine in preventing this disease.

From—a release of the Federal Security Agency
U. S. Public Health Service

FELLOWSHIPS IN HEALTH EDUCATION

Fellowships leading to a Master's Degree in Public Health in the field of Health Education are being offered to any qualified United States citizen between the ages of 22 and 40. Tuition, travel expenses for field training and a stipend of $100 a month will be provided out of funds furnished by the National Foundation for Infantile Paralysis.

Candidates must hold a bachelor's degree from a recognized college or university and must be able to meet the entrance requirements of the accredited school of public health of their choice. In addition to the degree, courses in the biological sciences, sociology, and education may be required. Training in public speaking, journalism, psychology, and work in public health or a related field are considered desirable qualifications. The year's training will begin with the 1947 fall term.

Application blanks may be obtained by writing the Surgeon General, United States Public Health Service, Washington 25, D. C., and must be filed prior to March 15, 1947.

HANDBOOK SOON AVAILABLE

The revised Handbook of Occupational Therapy will soon be available ($1.00) from the A.O.T.A. office. If you are interested in knowing about the organization and function of your national association and committees, this handbook provides the best possible reference. It should be a "must" for every state association and clinical training center.

O.T. ITEMS

A 12-inch vinylite record (unbreakable) has been made specifically for O.T. use. Its title is "Four Singing Games for Children" and it was arranged and sung by William Wendlandt. The games are Looby Loo, Did You Ever See a Lassie, Here We Go Round the Mulberry Bush, and Round the Village. The pace is sufficiently slow, and the verses are suitably spaced with musical intervals, to allow handicapped as well as normal children to follow the action. The record has been tried out on the pediatric floor at Wisconsin General Hospital at Madison with enthusiastic response from the children, and complete success as far as the O.T. program was concerned. C.O.D. $2.00 plus tax. Order from GME, 4 Franklin Avenue, Madison 5, Wisconsin.

Caroline Thompson, O.T.R.

CARD SOLITAIRE FRAME. Are you overworking your tired braid weaving frame? Here is a suggestion from the Cleveland Rehabilitation Center, to try as an alternative. It is an upright frame for playing card solitaire, and it provides active motion for the elbow and shoulder.

This easily constructed piece of equipment provides a majority of the features required for good functional activity. The game itself gives incentive to finish, it is easily learned, and it holds the interest of most patients. Since the cards are placed in an upright rack, and the rack can be raised or lowered on a standard, complete range of motion of shoulder flexion and abduction may be obtained. The frame can be tipped from vertical to horizontal, thus encouraging elbow extension.

Since there are many forms of card solitaire, each requiring a different length of time to complete, the patient has the satisfaction of finishing a game, regardless of his limitation. Coordination is necessary since each card has a separate compartment. This feature, in addition to the fact that the cards must be placed in position one at a time, limits substitution. The game necessitates repetition, hence it provides alternate contraction and relaxation of the muscles. Sorting the cards on the table allows sufficient time for the latter.

The rack has seven compartments in each of the thirteen horizontal rows. The wood forming the rows is on a slant to permit easy insertion and withdrawal, as well as clear vision of the cards. The frame is suspended at the desired height on two pegs which fit into the notches.

Mrs. J. R. Donaldson, O.T.R.

COLOR THEORY IN ACCIDENT PREVENTION. One of the more recent scientific developments by the Dupont Company is their color plan of three dimensional seeing which prevents accidents to a remarkable degree. By painting the more dangerous parts of power tools and machinery one color, and background parts another color in correct degrees of contrast, both accidents and fatigue are lessened. Write to the Dupont Company, Wilmington, Del., for leaflets. O. T. Rehabilitation Workshops could benefit by the proven theories.

Doris F. Wilkins, O.T.R.

SHOP HINTS

Discarded X-ray film makes useful containers for patients' privilege cards. Stapled, or blanket stitched, on four sides so the card is held safely inside the transparent envelope, they save much wear and tear on the card.

How is the medium of plastic being used in the civilian hospitals? What type of articles are made? What is considered to be the most practical and successful of the polishing materials?

Speaking of Projects

In making ceramic jewelery, wire from burned out kiln units may be used to make pin backs, loops on buttons, etc. The wire can be fired with the clay.

Stuffed toys can be suitable O. T. projects for patients with tuberculosis if "Bubbletex" is used as stuffing. Bubbletex looks like cellophane seaweed and is light and completely washable. It is easy to use, has no lint, and the shape of toys stuffed with it is not altered by washing.

Project: Silver Plating Copper Jewelry

Equipment and Materials used:

1 Electric Hot Plate	
3 Dry Cell Batteries (Hardware Store) @ 35c.	$1.00
1 Porcelain stew pan (Hardware Store)	.50
3 Stone Crocks (gal.) (Hardware Store) @ 50c.	1.50
1 fine mesh wire brush (Hardware Store)	1.00
1 silver anode	
Clear lacquer	
4 solutions (formulas given in processes) Wholesale Drug Co. - Cost between $9.00 and $10.00	9.50
	13.50

(1) Cleaning in hot solution with current and anode. Attach anode to negative terminal and article to positive terminal of dry cell battery. Formula: 6 oz. oakite #90 (powder) to 1 gal. water. (Oakite Products Inc., Continental Life Bldg. — JE 0511), or

3 oz. Trisodium Phosphate
2 oz. Sodium Metosilicate
1 oz. (Caustic Soda
(Sodium Hydroxide

Attach Electric Hot Plate. Put solution in Porcelain Stew Pan and heat but do not let boil. Put both the anode and article to be plated in solution for ten minutes. Remove and scrub with brush. Rinse throughly in running water. Looks dirty and black after cleaning. Do not handle with hands, use tweezers or attached wire.

(2) Bright Dip: Put in a stone crock a 20% solution of Hydrochloric acid (room temperature). Dip article to be plated in solution for two minutes. Remove and rinse thoroughly. Looks bright. Do not handle with hands.

(3) Silver Strike Solution with current and anode.

Attach article to negative terminal and anode to positive terminal of dry cell battery.

Formula: 9 oz. sodium cyanide
¾ oz. silver cyanide
1 gal. water (room temp.)

Put article and anode in solution in stone crock for three to four minutes. Agitate lightly the article being silvered. Remove and rinse thoroughly. Article will have a slight coating of silver, looking whitish. Do not handle with hands.

(4) Silver Tank with current and anode.

Attach article to negative terminal and anode to positive terminal of dry cell battery.

Formula: 9 oz. Potassium cyanide
6 oz. Silver cyanide
16 oz. Potassium Nitrate
1 gal. water (room temp.)

Put article and anode in solution in stone crock for 30 minutes, agitating every so often, 5 or 6 times.

Remove, rinse, first cold water, then hot water.

Buff with wire brush.

Lacquer.

Sarah Barnes, O. T. R.

Packages of pencils can be made to go further for ordinary purposes in the workroom with a lot of people, if the pencils are sawed into halves.

The long awaited, war-cancelled, frequently-requested, inexpensive cotton has arrived - 1200 yard balls, 4-ply. Sears, Roebuck Company, Boston.

LETTERS

Dear Editor:

Clinical training programs are now being made months in advance which is, of course, highly desirable but the arrangement presents an acute problem to the department employing only one therapist. The hospital administrator is concerned with continuity of service of the department and having recognized the obligation of student training, he prefers that they be scheduled consecutively. However, the therapist needs adequate vacation period which must be planned at a time when it is possible to procure a registered therapist to work in her place and maintain clinical training standards. It should be possible to make these plans six months ahead. Would it be possible to announce date and place of the following year's meeting at the current convention?

Marjorie Ball, O. T. R.
Elizabeth D. Waller, O. T. R.
Clotildo Brown, O. T. R

Dear Editor:

It has always been of considerable worry to me that facilities for learning more about occupational therapy, its theory and its practical use, was at a minimum for graduate therapists. Some of us find positions in remote locations where there are no schools, good libraries, clinics, or other fields of interest to help us keep up with the new trends of thought and activities.

I certainly hope through our national organ "The American Journal of Occupational Therapy" some stress will be applied toward keeping us up on the current changes. Some of the technics which we used ten or fifteen years ago are definitely outmoded. If it were not for the intense interest of some therapists in trying to discover what is happening outside their own little niches, I am afraid the O. T. programs in many hospitals would suffer sorely.

Katherine Habel, O. T. R.

Dear Editor:

This is a plea for broader education for occupational therapists.

After eight years of experience in the field, I am a World War II veteran, with the opportunity of going back to school. Having had so many specialized courses in my preparation for occupational therapy, I feel the need now of more basic cultural knowledge. Rather than taking further courses in psychology and sociology, I am studying literature and history. A deeper knowledge of these, I believe, will better fit me for whatever comes in life, and also for a return some day to the occupational therapy field.

Let us all remember, when advising future therapists, to stress the professional person's need for a wider view of life that a broad cultural background can help to give.

Harriet J. Tiebel, O. T. R.

Dear Editor:

All the members of the Maryland Occupational Therapy Society would like to vote their great appreciation to Dr. William R. Dunton, Jr., for the editing of "O. T. & R." and for his loyal and interested efforts over all these years of giving us such a helpful and outstanding publication. This magazine not only gave O. T.'s great inspiration but it was one which we were proud to find in the libraries of our medical and social organizations.

Muriel Zimmerman, O. T. R.

Dear Editor:

Therapists all over the country are finding themselves out of school and sadly lacking in a basic knowledge of crafts. Many would be willing to devote time to learning more of crafts if they knew where to go or how to manage time for it while working.

Technically, the therapeutic tools at the disposal of an occupational therapist include every activity which she can "harness" or "tailor" to comply with a specific therapeutic aim. Occupational therapy schools and train-

ing centers acquaint students with those activities which have proved to be applicable, and they demonstrate the methods of scientific application. Training in most subjects is necessarily limited due to the vast amount of material to be covered. The most which any student can hope to gain is a good "working knowledge" of a craft or activity. When they graduate and are employed as therapists this "working knowledge" is quite suddenly not enough. They often find themselves in positions where they must develop and analyze crafts which will meet the needs of their particular hospitals. If they are to be a credit to the profession they must take measures for their own self improvement. They must not only increase their scientific knowledge but they must learn thoroughly the crafts which they intend to use. The question arises — "Where will I turn for this advanced training?"

Learning from books seldom proves to be adequate, and attendance at organized classes is denied many therapists because of the isolated location of their hospitals. Often the result is that the O. T. programs are ill-suited to the given situation, and the possible scope of occupational therapy is never demonstrated to the medical staff. The staff, in turn, never learns to respect or intelligently utilize the department. The work of the therapists becomes routine, uninspired and unscientific. There must be a basic thorough understanding of crafts, the tools of the therapist, before intelligent analysis and application of them can be made.

As schools become better organized this deficiency will undoubtedly be corrected in the training program, but, for the present, wouldn't it be a good plan to set up strictly craft refresher courses for graduate therapists who find themselves in a rut and inadequate in this respect?

Peggy O'Brian, O. T. R.

* * *

Dear Editor:

To the occupational therapy student clinical training provides a very different and challenging experience from any she has had at school. It gives her the opportunity to try to put into practice the many things which she has learned and which, up until her first training period, are known to her in theory only.

One of the first problems of the student occupational therapist is her approach to patients. Although she may have observed patients at clinics during the academic year, she must now make friends with them, gain their confidence, and establish a relationship through which she will be able to help them to the greatest degree. Many types of patients —psychiatric, orthopedic, tuberculous, adults and children—must be treated, and the occupational therapist must learn to adapt herself to their personalities and moods and to understand them and their problems if her work is to be of any value. This is not an easy matter for all students.

Learning the techniques and principles of crafts at school is one thing, and being able to teach those crafts to beginners is another. The student often finds herself faced with the problem of teaching a patient to do something which she herself may have done only once at school. She must guide patients in work of which she herself is very unsure. And at the same time she must try to keep the confidence of the patient. The graduate occupational therapist has to face this problem too, but usually her work is confined to one or a few fields, whereas the student is expected to help in many different shops and with numerous types of craft work.

Included as a difficulty in some instances is the students' disillusionment in their profession and in some of the persons engaged in it. Many students have built up wonderful ideas of the goodness and worth of occupational therapy and are surprised and disheartened at what they do or do not find in actual occupational therapy programs. Personnel may not live up to their conception of the ideal occupational therapist. They find fault with much and see many things which they would do differently. However, this is a good thing, for there is room for improvement in our profession, and we must be aware of its shortcomings if occupational therapy is to progress.

There are many pleasant and inspiring aspects of training. But the occupational therapy student expects to find difficulties, and she goes into her clinical training with the hope that, through her own efforts and the help of those with whom she comes in contact, she may learn to overcome them.

Muriel E. Zimmerman, O. T. R.

BOOK REVIEWS

Operations Manual for the Placement of the Physically Handicapped. U. S. Civil Service Commission; Superintendent of Documents, Washington, D. C.

Many Occupational Therapists interested in prevocational activities have at one time or another wished for a practical working list of suggested jobs to match against the talents of their handicapped patients. Such a list would furnish both therapists and patients with the stimulus of a concrete goal. And such a list is now available in the U. S. Civil Service Commission's "Operations Manual for the Placement of the Physically Handicapped" distributed by the Superintendent of Documents, Washington 25, D. C., at a cost of sixty cents. Copies may be found in the Documents section of University Libraries and in some local offices of the State Employment Services.

The largest section contains a listing of civil service jobs by handicap, under such headings as "Positions suited to a person with an amputation of one arm," etc. A second section describes the conditions and requirements of each job.

It has been stated and perhaps rightly that people should be placed in jobs according to their abilities rather than their disabilities, and in support of this any canvass made of the actual occupations of a given number of disabled persons is apt to yield almost as many types of work as persons listed. However, the wide variety of suggestions in this manual under each handicap leaves ample room for selection on the basis of talents, temperament and education as well as physical condition. The ingenuity of the therapist in combining information about local employment conditions, the test results furnished by the psychologist and the educational and vocational history of her patient with her own specific knowledge of his personality and performance will ensure a sensitive use of this over-flexible tool.

C. G. T.

The Challenge of Polio (The Crusade Against Infantile Paralysis). ROLAND H. BERG. The Dial Press, N. Y.

This book is a timely and important addition to others which have been written on the subject of Poliomyelitis. It might well be considered a must for each and every person who may work with the Polio patient, or talk with the patient's family.

The subject of Polio seems too vast to be treated in any volume of 200 pages, yet one closes the book with a feeling of having completed a comprehensive survey.

Perhaps the most encouraging factor in reading the text is the realization that although the history of Polio incidence is long, research workers have shown no discouragement and they are attempting to solve the problem from so many angles that the inevitable result must be success. Much of this research is made possible by means of grants from the National Foundation for Infantile Paralysis. It is interesting that although Mr. Berg is the science writer for the Foundation, the book is in no way propaganda.

As interest in the Kenny treatment is, and will continue to be, great, it is gratifying to read a careful analysis of this treatment—the Kenny technique is good, but it is not the spectacular cure which the public has been led to believe.

L. R.

Music In Medicine. SIDNEY LICHT, M.D. Pp. 132. Boston, Massachusetts, New England Conservatory of Music, 1946

Music In Hospitals. WILLIAM VAN DE WALL, Head, Adult Education Section, Education Branch, Internal Affairs and Communications Division office of Military Government for Germany, U. S. Paper. Pp. 86 with 1 illustration. New York; Russell Sage Foundation, 1946

Music as a Modality of Occupational Therapy. ARTHUR FULTZ. (War Med. 5: 193 (March) 1944).

These three interesting approaches to the problem of the use of music in the care of patients are recommended to those wishing to survey this subject. Differing somewhat in emphasis they nevertheless serve to draw attention to the functional use of music, in certain cases, under the prescription of the attending physician. Occupational Therapists have long used music for diversional and morale building purposes and in the treatment of mental patients. The possibilities of its application to other fields is an interesting speculation.

Such discussions are also useful in pointing out to musicians the need for supervision by trained Occupational Therapists wherever music is to be attempted as a part of a regular program of treatment.

K. R.

Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability. ROGER G. BARKER, BEATRICE A. WRIGHT and MOLLIE R. GONICK. Social Science Research Council, New York. Price $2.00.

This review and appraisal of research upon adjustment to constitutional disabilities is made timely by the problems of the handicapped veteran. The authors treat adjustment to physical handicap as a problem in social psychology involving the effects of a deviation in physique upon the personality and social behavior of the individual.

A chief value of the critique will consist in the stimulation of further research with greater precision in definition of concepts and more rigid methods. In spite of the limitations of past research, there emerges an important body of knowledge of real value to those who are engaged in the treatment and counseling of the handicapped.

Microbes That Cripple. T. ARTHUR TURNER, written and illustrated under the direction of Edward L. Compere, M.D. Published by the National Society for Crippled Children, Inc. Elyria, Ohio, 1944. Price $2.50.

This book furnishes an excellent foundation in microbiology for all workers in the health field. It is presented in such a human interest fashion that many complex activities of these cocci, bacilli, and spirilla are remembered longer than if one had to spend hours "digging" for this knowledge.

Discoveries and contributions of famous men are given as a background for the specific discussions which follow.

The author discusses osteomyelitis, tuberculosis, syphilis, poliomyelitis, rheumatic fever, arthritis plus complicating diseases. Measles, which remains one of the most mysterious of diseases, whooping cough, and influenza are not usually crippling but may produce sequelae.

The author goes on with a fine discussion of "Public Hygiene and The Prevention of Crippling." He includes a very complete glossary and bibliography which gives suggestions for those interested in further study or research.

"Add 'le' and a little imagination to the word 'creep' and the resulting word is 'cripple.' Both creep and cripple are derived from the Teutonic kriupan, meaning to crawl, creep, move slowly and painfully."

I. M.

A Textbook of Medicine. By American Authors, Edited by RUSSELL L. CECIL, A.B., M.D., ScD. Associate Editor for Diseases of the Nervous System; FOSTER KENNEDY, M.D., F.R.S.E. 6th Edition, Revised. W. B. Saunders Co., Philadelphia, 1943.

This text is an exceedingly valuable reference for any occupational therapy department, but particularly one which has students in training.

Short introductory chapters preface the larger sections of the book and are condensed statements of the general physiologic principles underlying the diseases included.

The sections are: infectious diseases, diseases of doubtful or unknown origin, diseases of allergy, diseases due to physical agents, diseases due to chemical agents, the intoxications, deficiency diseases, diseases of metabolism, diseases of the digestive system, respiratory system, spleen and reticuloendothelial system, diseases of the ductless glands, locomotor system, diseases of the nervous system.

The discussion of each disease is subdivided as: definition, etiology, pathology, incidence, symptomatology, complications, differential diagnosis, prognosis, treatment and bibliography.

I. M.

Muscle Testing, a manual published by the W. B. Saunders Company, Philadelphia and London, 1946, brings a new source of information to the Occupational Therapist on testing muscle strength.

The authors, Lucille Daniels, Marian Williams and Catherine Worthingham have chosen a unique way of representing their material.

Each test of the strength of muscle groups or individual muscles, with pertinent factors which relate to it, is treated as a unit. Pictures and simple text have been employed. Thus, a diagrammatic line drawing shows the range of motion possible for each joint on which the muscles to be tested act; an anatomical drawing shows muscle origin and insertion on bones, soft tissue attachments are given when they are of particular importance. Factors limiting the motion, fixation of the bone or segment from which the main acting muscle originates are mentioned. The nerve supply, origin and insertion of each prime mover responsible for the completion of the full range of motion are listed in chart form.

The actual manual testing of muscle strength, ranging from Normal and Good, to Fair, Poor, Trace and Zero also is described and explained through text and pictures, which give test positions for the varying degrees of power, the direction of muscle contraction and the application of resistance and stabilization.

The book includes a sample chart, supplied by the National Foundation for Infantile Paralysis, Inc., for recording muscle strength, muscle spasm or contractures. To make the manual a real working tool, space has been left for notes and the addition of any special tests which the examiner may wish to record. A history of the development of muscle test serves to make the content more complete and interesting.

The choice of the tests described has been explained by the authors, who state: "The technique of muscle examination presented in this manual is based on the work of a selected number of investigators. No attempt has been made to present all the tests which have been devised for any particular muscle or muscle groups. Instead, the emphasis has been placed on the testing of prime movers in relation to the principal joints of each segment of the body."

Although muscle testing lies more in the realm of the physical therapist, the book should and will be of help to the occupational therapist. The material presented will serve as a valuable means of reviewing anatomy, neurology and kinesiology. It will enable the occupational therapist to understand to a greater extent the work of the physical therapist and to interpret test results. The knowledge of test position, test movement, and grade of power present is an indispensable guide in the selection and application of activities for the strengthening of weakened muscles or muscle groups. Those working with patients suffering from loss of muscle power, be this due to disease or injury, have a good opportunity to substantiate and improve their technique of treatment through the careful study of this manual.

E. M. O.

Old Quilts by WILLIAM RUSH DUNTON, JR., M.D., recently published by the author at 33 North Symington Avenue, Catonsville, Md., contains the most authoritative and detailed treatment of this distinctively American art of "piecing and patching" that has appeared so far. Dr. Dunton explains his long interest in this subject from the points of view of physician, artist and historian. He has collected many excellent illustrations of intricate specimens and gives his reader a careful account of their ownership, construction and place in the life of their period. The quilts that Dr. Dunton describes are, for the most part, the aristocrats of their kind and contain almost unbelievable evidence of the skill and taste of their long dead makers.

To anyone thinking of developing a program of quilt-making, this book should be most valuable. It should also add materially to the enjoyment and appreciation which the lay person has in the possession of such family treasures, if he is so fortunate, or which he receives from seeing them in museums and exhibitions.

K. R.

Easy-To-Do Crafts

TO ASSIST OCCUPATIONAL THERAPISTS IN THE USE OF CONSTRUCTIVE ACTIVITIES

Because Prang Textile Colors and Carvocast are so easy to use, they are especially suited for Occupational Therapists. In various hospitals where they have been tried out, we have received glowing testimonials in their praise. We will be glad to send you FREE descriptive folders on Prang Textile Colors and Carvocast.

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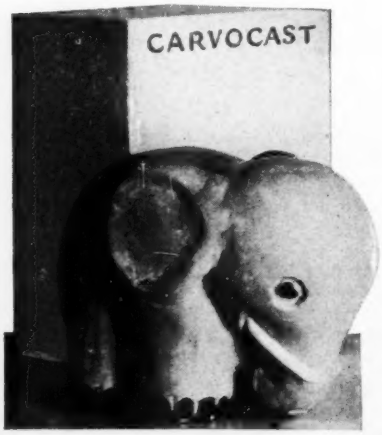

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